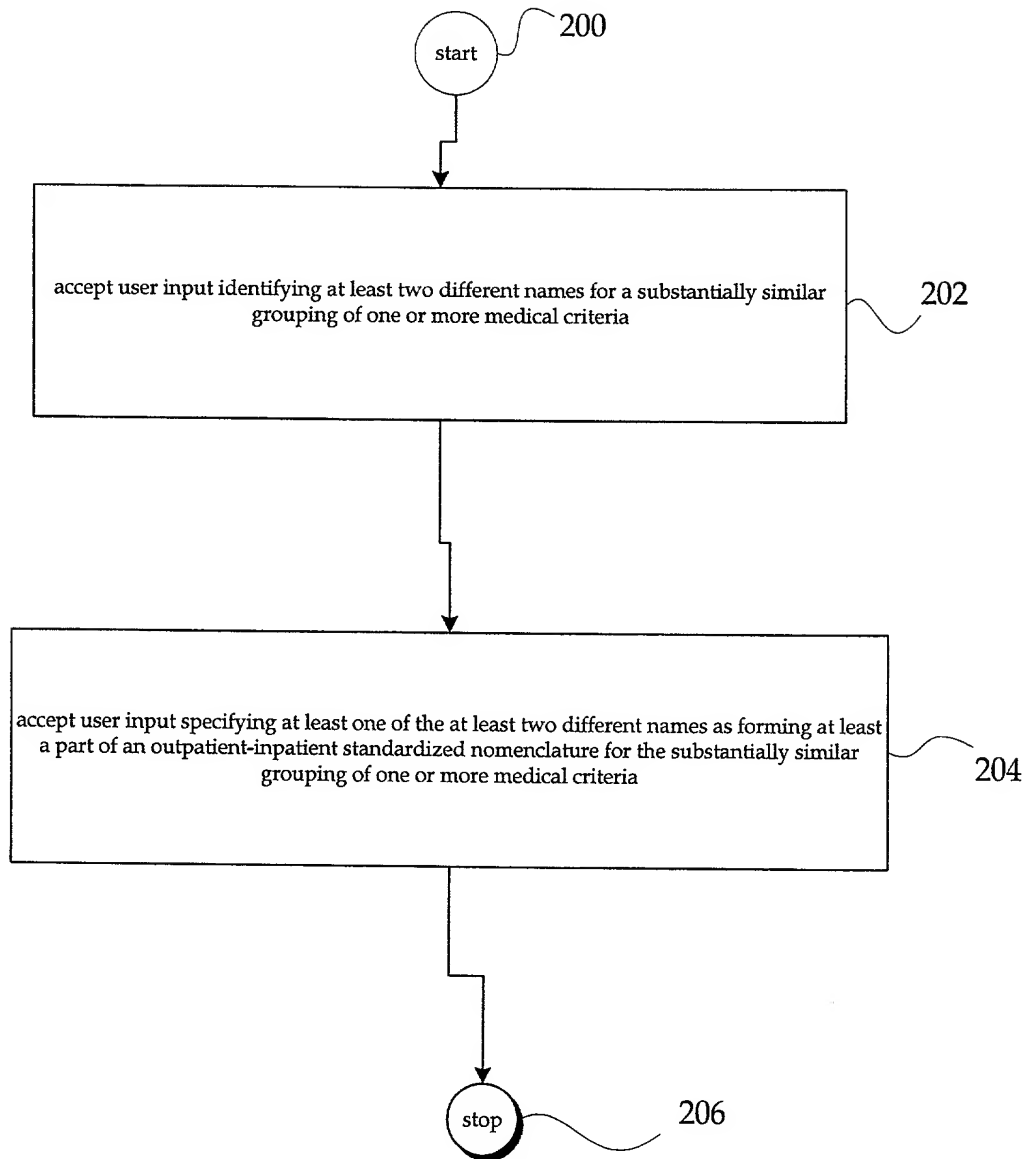


**Fig. 1**

*Fig. 2*

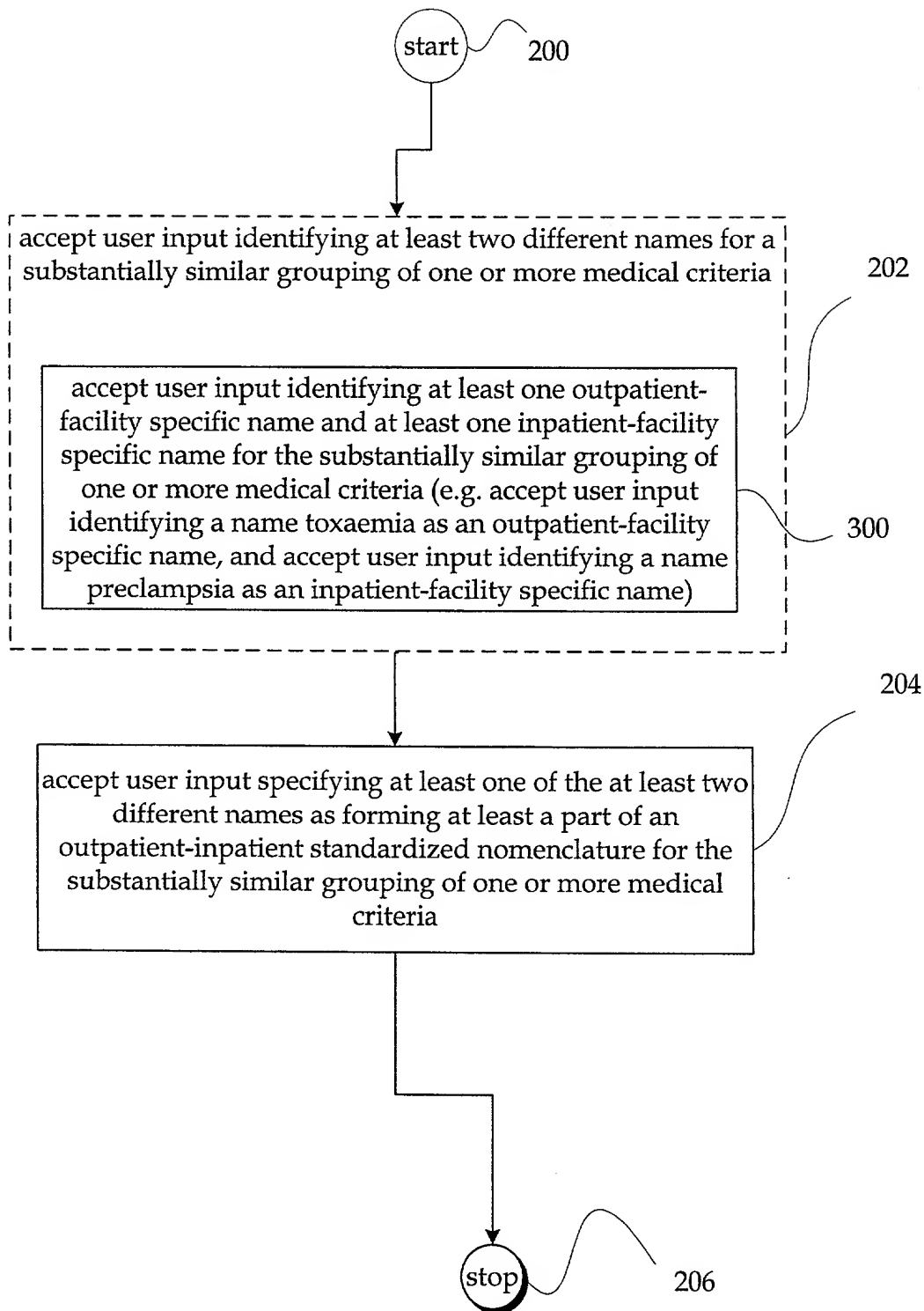


Fig. 3

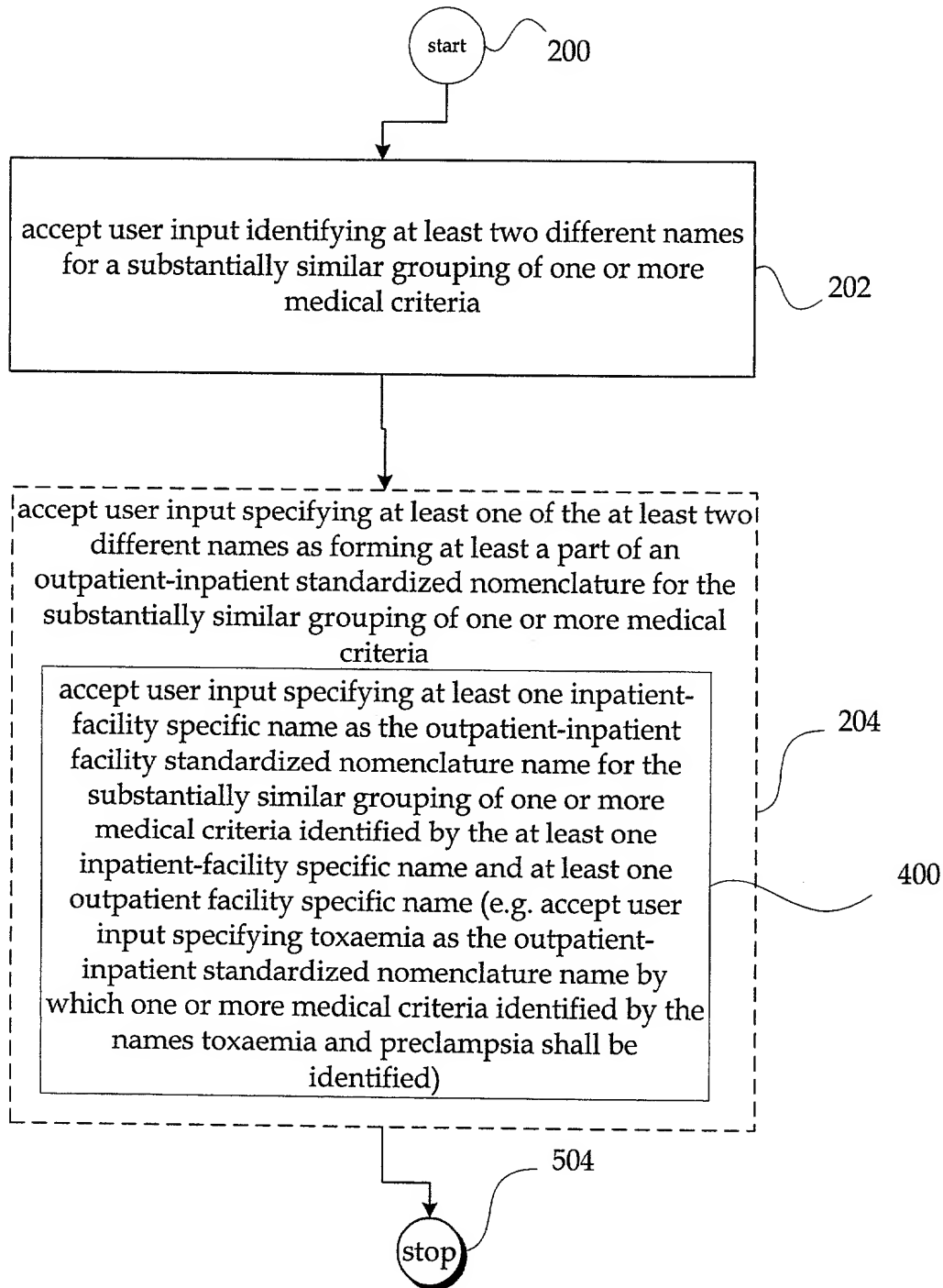
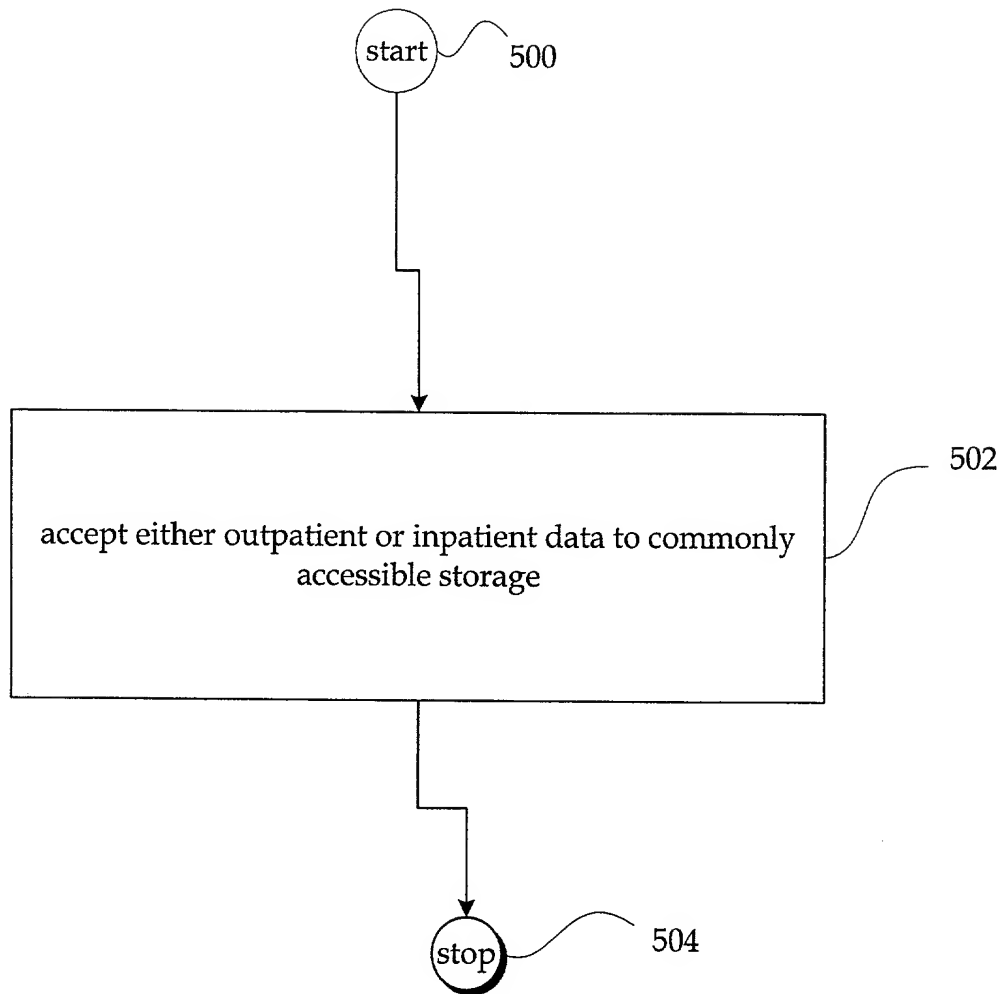


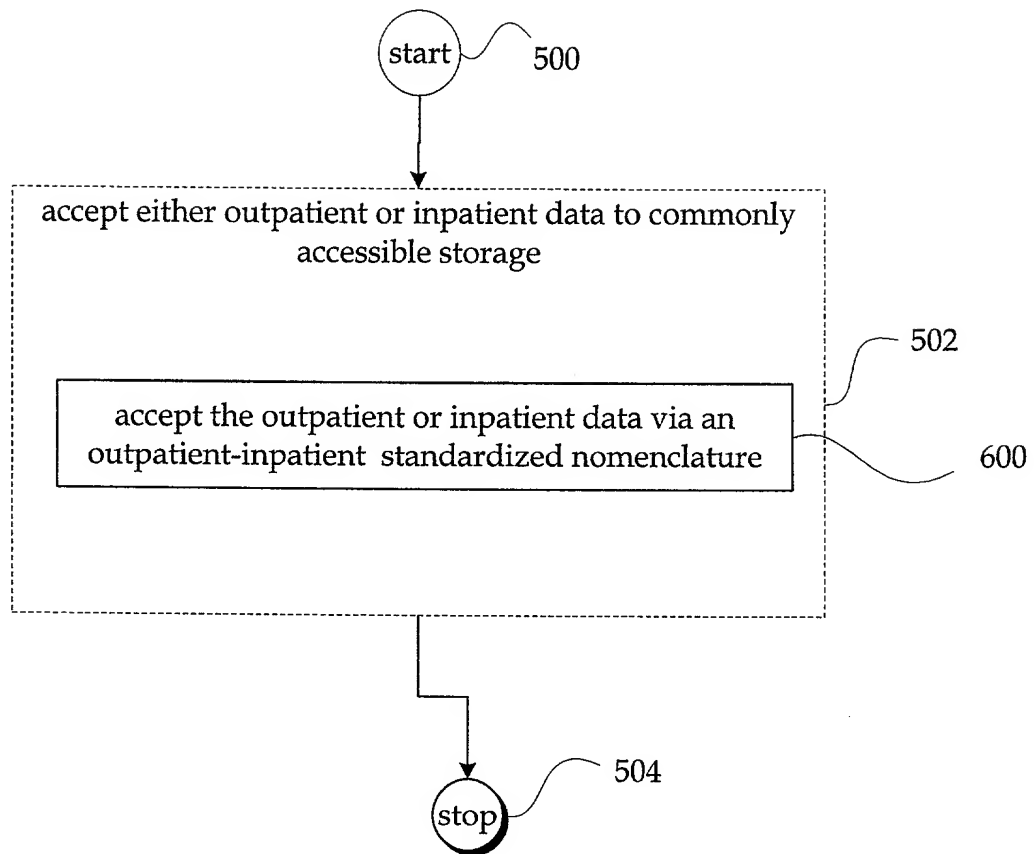
Fig. 4



5/55

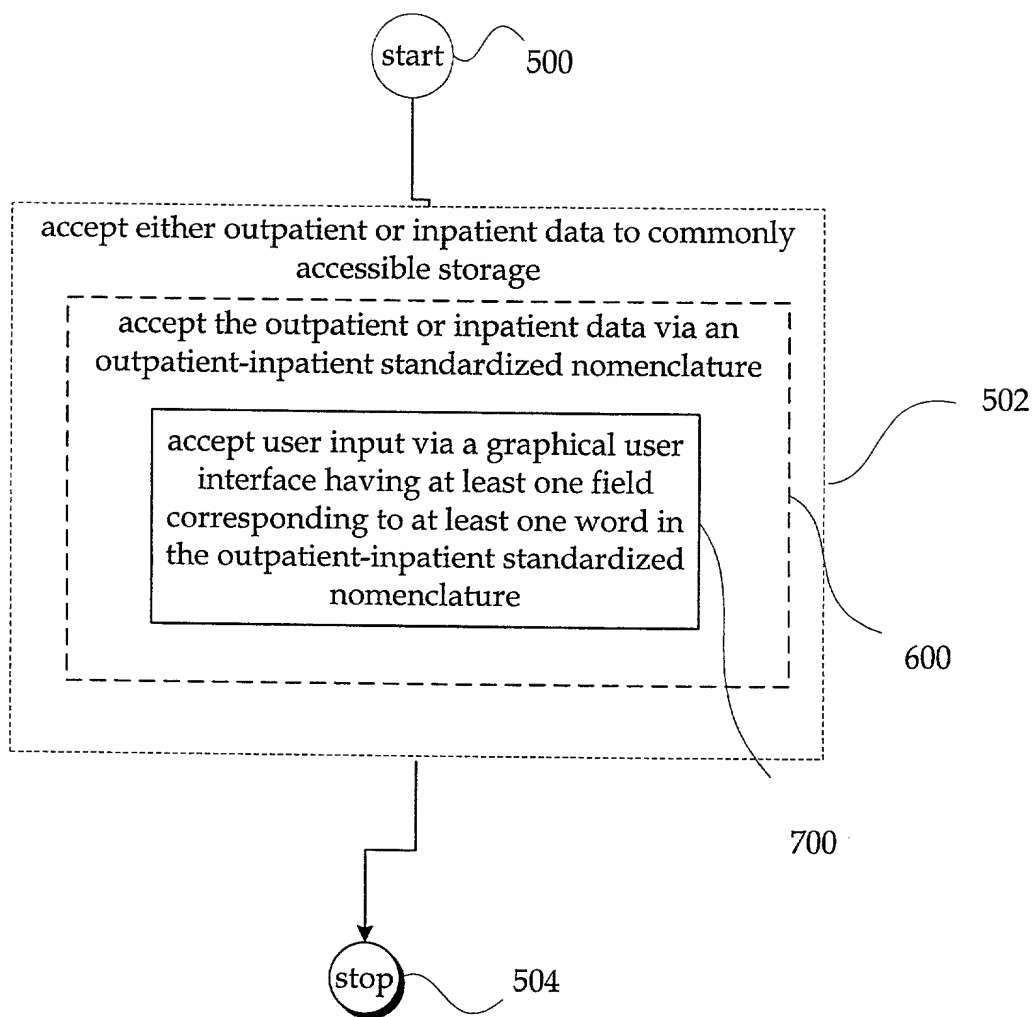


*Fig. 5*



*Fig. 6*

7/55



*Fig. 7*

**STORC - Standard Obstetrics Record Charting System** \*\*\*\*\* TRAINING DATABASE \*\*\*\*\*

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

History for Patient Name: Patient SSN Disposition: DELIVERED

**COMPLICATED** Age: 38 G/P: 5/1-1-3-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/RH: A- STD LABS NKDA

Assoc. Visit/Encounter: **ADMISSION** 20 Jul 1999 1610 SF533 History/Physical Data Reviewed By/Date: drmann 21 Jul 1999 1801

PMH/PSH OB Hx Family/Social/Subst Hx Allergies/Menstrual Hx ☐ SF533 is/will NOT be entered in STORC

☒ Conditions for all other history categories not listed below are normal. Note: PMH-PSH and the remarks data will carry over from past pregnancies.

Past Medical Condition(s)	Pb List?	Plan for Pb List	Resolved?	Comment
ASTHMA	<input type="checkbox"/>		<input type="checkbox"/>	since birth: on azthmacort inhaler.
PELVIC INFLAMMATORY DISEASE	<input type="checkbox"/>		<input checked="" type="checkbox"/>	in 1995. Treated successfully with xxx.
CONDYLOMA, VAGINAL	<input type="checkbox"/>		<input type="checkbox"/>	
CONDYLOMA, VULVAR	<input type="checkbox"/>		<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>		<input type="checkbox"/>	
CONSTIPATION, CHRONIC	<input type="checkbox"/>		<input type="checkbox"/>	
COPD PULMONALE	<input type="checkbox"/>		<input type="checkbox"/>	
CORONARY ARTERY DISEASE	<input type="checkbox"/>		<input type="checkbox"/>	
CORRECTIVE LENSES	<input type="checkbox"/>		<input type="checkbox"/>	
OSTROCONDRIITIS	<input type="checkbox"/>		<input type="checkbox"/>	
CROHN DISEASE (REGIONAL ENTERITIS)	<input type="checkbox"/>		<input type="checkbox"/>	
CYSTITIS, SPECIFY	<input type="checkbox"/>		<input type="checkbox"/>	
DEEP VENOUS THROMBOSIS, PRIOR PREGNANC	<input type="checkbox"/>		<input type="checkbox"/>	
DEEP VENOUS THROMBOSIS, NOT PREG RELAT	<input type="checkbox"/>		<input type="checkbox"/>	

Add... Delete...

New Remarks: (dbl click for more) Prev Remarks...

Add Surg... Delete...

☒ Mark SF533 History and Physical Data Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Microsoft

Start Std Inbo CD Inbo CHC CHC FW RE W Mic 4 ST.. 253 PM

752

750

Fig. 7A

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Ppocs Meds Compl Pb List Notes

**Stages of Labor and Delivery for BOND** Patient Name; Patient SSN **DELIVERED-CURRENT**

**COMPLICATED** Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 W/7 Type/Rh: A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

**General Information**

Prior C-Section? ☐ Vaginal Birth Candidate? ☒

**First Stage**

Onset Date: 23 Nov 2001 Time: 0630

Progress: **AUGMENTED**

Duration: 9hr 8min

**Augmentation**

☒ Oxytocin Augmentation?

Duration of Oxytocin: 6 hr 20 min

Highest Dose: 9

Enter Other Medications Given During Labor/Delivery:

**Analgesia**

Analgesia	Date (mm/dd/yyyy)	Time
FENTANYL	23 Nov 2001	

Add Delete

**Anesthesia**

Anesthesia	Date (mm/dd/yyyy)	Time
INTRATHECAL ANESTHESIA	23 Nov 2001	
EPIDURAL	23 Nov 2001	

Add Delete

**Induction**

Induction Type	Date (mm/dd/yyyy)	Time
NO INDUCTION	23 Nov 2001	

Add Delete

SVD: Op Vag C-Section

☒ Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Microsoft

Start Sid Inb CD Inb CH CH FW RE Mic S 2:21 PM

Fig. 7B

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

10/55

**STORC - STandard Obstetrics Record Charting System**

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

**Stages of Labor and Delivery for** Patient Name; Patient SSN **Disposition: DELIVERED-CURRENT**

**COMPLICATED** Age: 35 G/R: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

**Second Stage**

Onset Date: 23 Nov 2001 Time: 1538 Duration: 1 hr 12 min

Episiotomy Date (mm/dd/yyyy) Time: Add Epis. Delete...

MIDLINE EPISIOTOMY 23 Nov 2001

Laceration Date (mm/dd/yyyy) Add Lacer. Delete...

NO LACERATION 23 Nov 2001

Sutures: 2-0 VICRYL SUTURE 2-0 CHROMIC SUTURE

Repair: REPAIR OF LACERATION/EPISIOTOMY IN THE USUAL FASHION

Skin Prep: BETADINE Hospital/Location: LRMC

**Newborn Information:**

Wt(kg)	Sex	Delivery Type/Outcome	Liveborn?	Neo Death?
3560	FEM	VAGINAL DELIVERY	Y	N

**Third Stage (Placenta)**

Onset Date: 23 Nov 2001 Time: 1650

Plac. Deliv: SPONT DELIVERY OF PLACENTA

Deliv. Date: 23 Nov 2001 Time: 1656

Appearance: INTACT & NORMAL

Vessel: 3 VESSELS

☐ True Knot ☐ Velementous Insertion

Duration: 0 hr 6 min

**Summary and Delivery Comment**

EBL: 300 ml Dur of Rupture: 12 hr 50 min

Dur Total: 10 hr 25 min

SVD, Op Vag, C Sect

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Microsoft

Start Sld. Inb. CD Inb. CH. CH. FW. RE. Mic. S. 2:21 PM

Fig. 7C

11/55

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Functional Area: Discharge

Key Info: General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

**Stages of Labor and Delivery for** Patient Name; Patient SSN **Disposition: DELIVERED-CURRENT**

**COMPLICATED** Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

**List of Common Delivery Procedures**

- AMNIOINFUSION
- ANTIBIOTICS, IV
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INJECTION, ANTIBIOTICS
- INJECTION, RH IMMUNE GLOBULIN
- IUPC PLACEMENT
- POSTPARTUM TUBAL LIGATION
- REPLACE EPIDURAL
- TRANSFUSION, BLOOD EXPANDERS
- TRANSFUSION, FRESH FROZEN PLASMA
- TRANSFUSION, PACKED RED BLOOD CELLS
- TRANSFUSION, PLATELETS

Add Selected Procedure for Patient...

**Current List of Other Procedures for Selected Patient**

Procedure	Date	Time	Perf
FETAL SCALP ELECTRODE	23 Nov 2001	1350	
FOLEY PLACEMENT	23 Nov 2001	1410	

Refresh List Enter Additional Procedures...

SVD: Op Vag: C Sect: ☒ Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Microsoft

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Fig. 7D



12/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 Labor and Delivery Information Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

List of Common Delivery Complications

- BLADDER INJURY
- BOWEL INJURY
- CARDIOPULMONARY ARREST, NOT RESUSCITATED
- CARDIOPULMONARY ARREST, RESUSCITATED
- EXTRAUTERINE PREGNANCY (EUP)
- HEMATOMA, VAGINAL
- HEMATOMA, VULVAR/PERINEAL
- HEMORRHAGE
- INDUCTION OF LABOR, FAILED - SPECIFY
- INDUCTION OF LABOR, MECHANICAL - FAILED
- MATERNAL MORTALITY
- MULTIPLE GESTATION WITH MALPRESENTATION
- MULTIPLE GESTATION, LOSS OF ONE OR MORE

Add Selected Complication for Patient

Current List of Other Delivery Complications for Selected Patient

Delivery Complication for Mother	Comment
----------------------------------	---------

Refresh List Enter Additional Complications

SVD: Op Vag C Sect

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Microsoft

Start Sld. Inb. CD. Inb. CH. CH. FW. RE. Mic. S. 2:22 PM

Fig. 7E



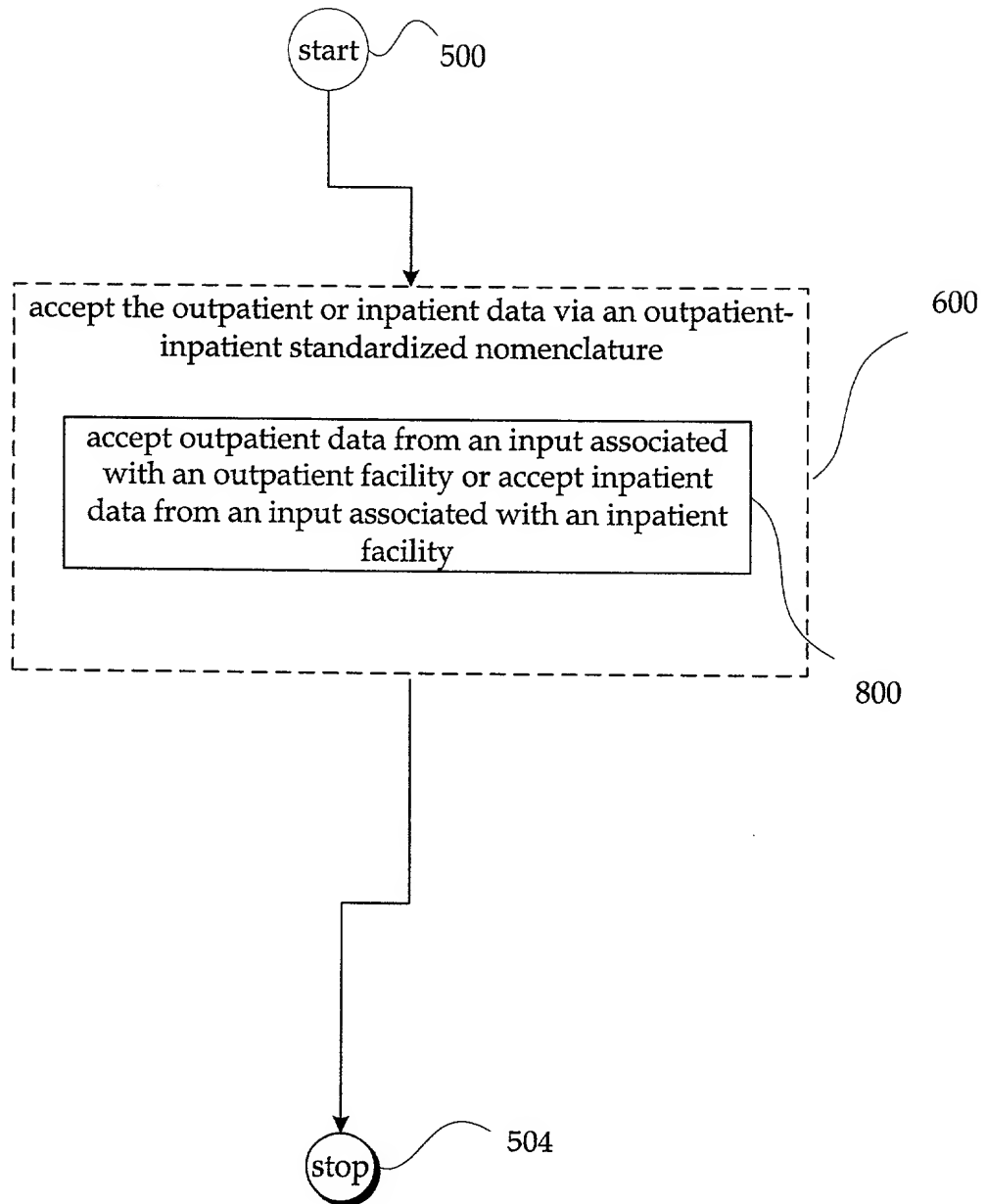
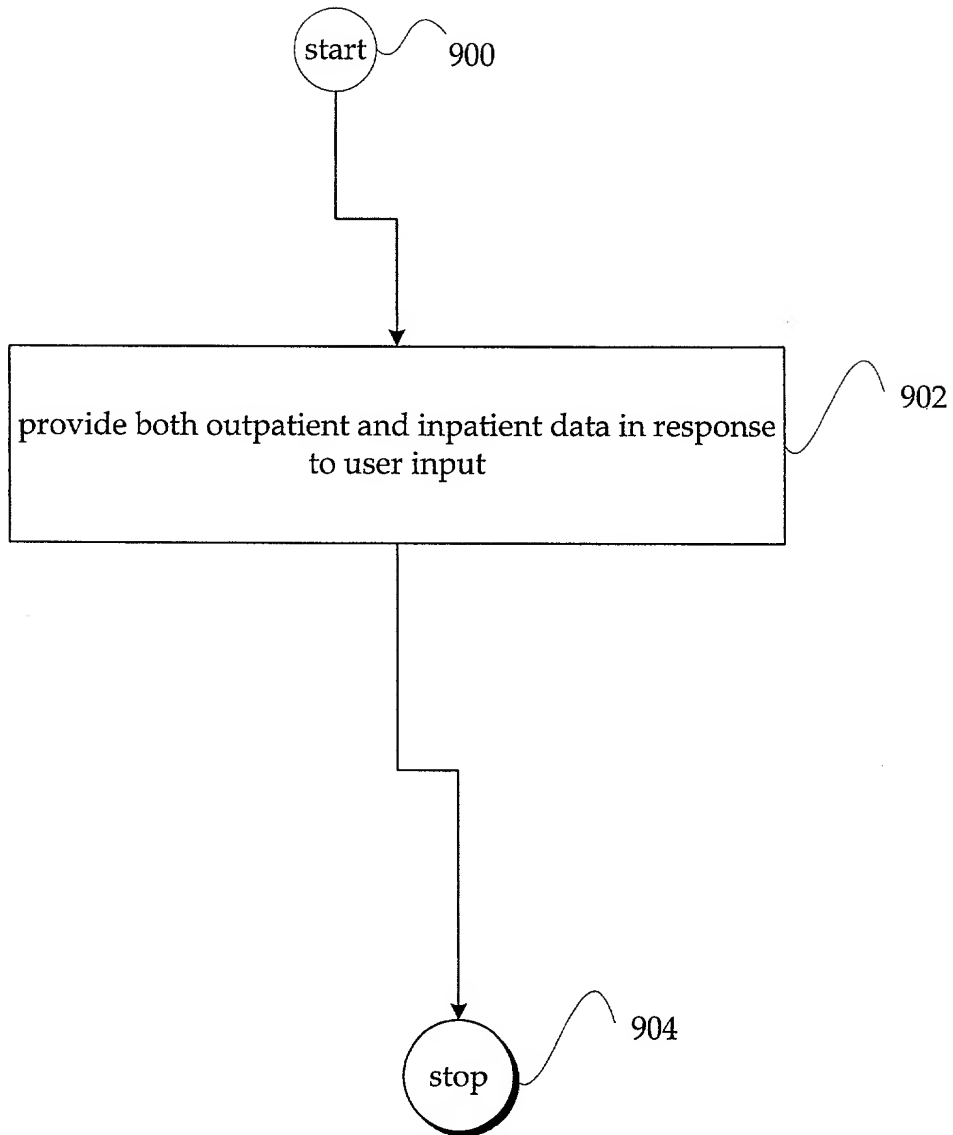
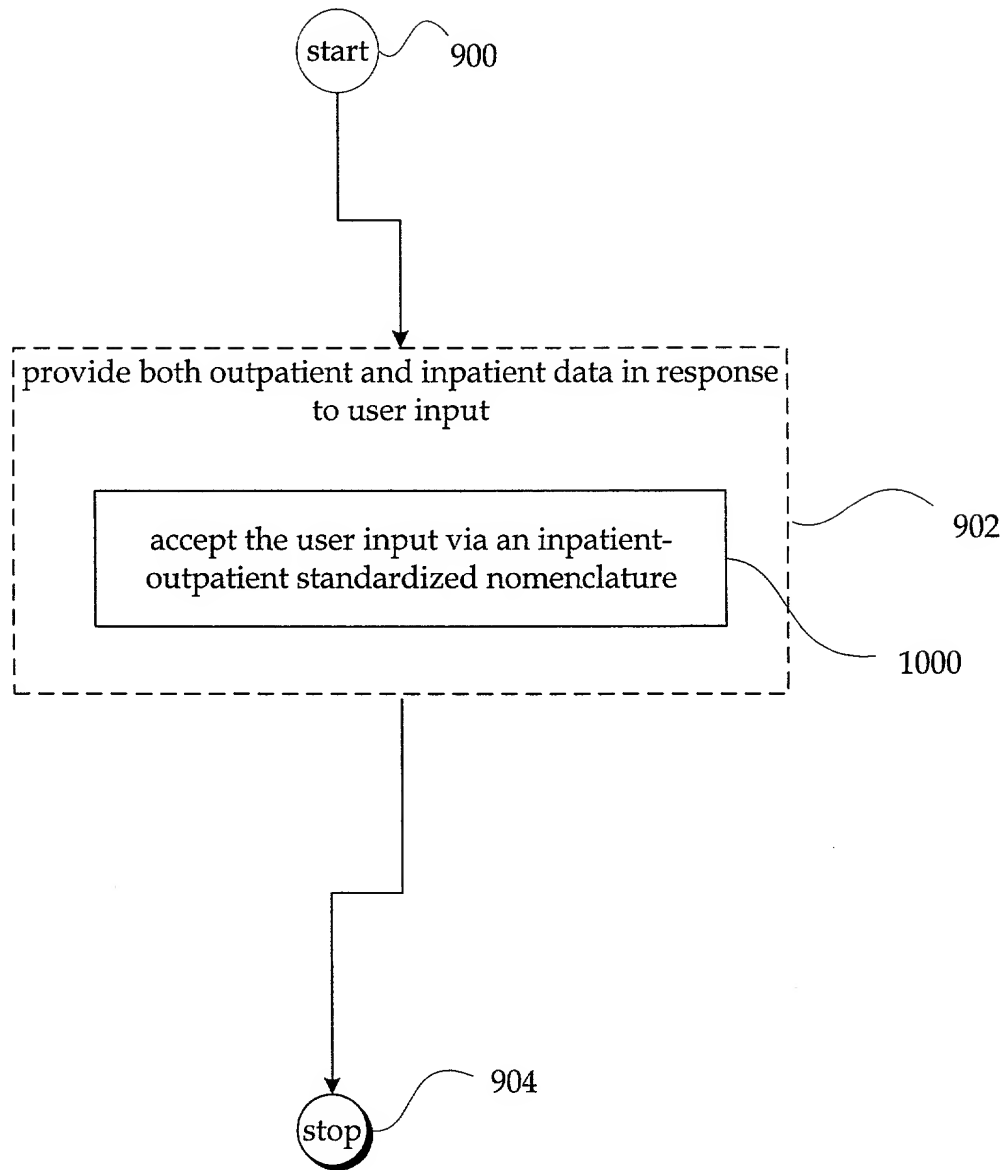


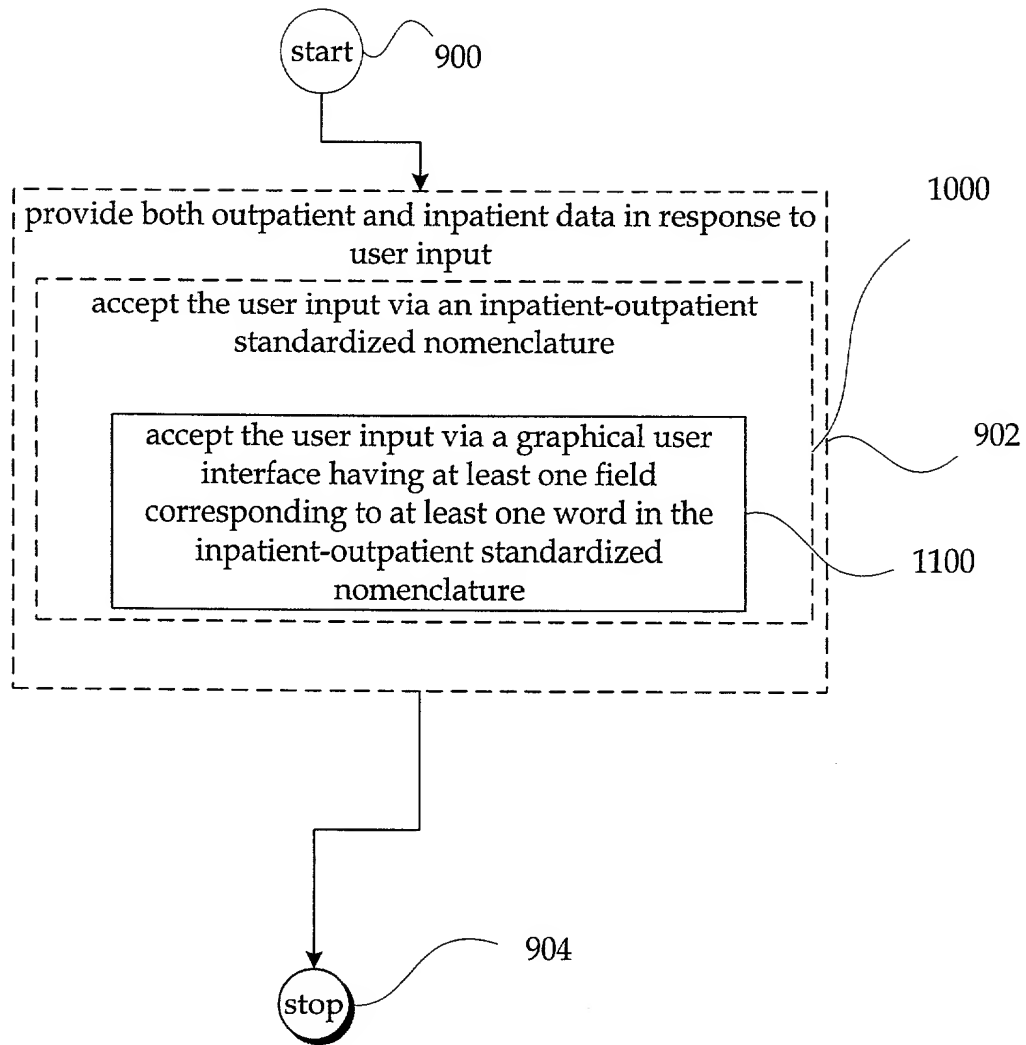
Fig. 8



*Fig. 9*

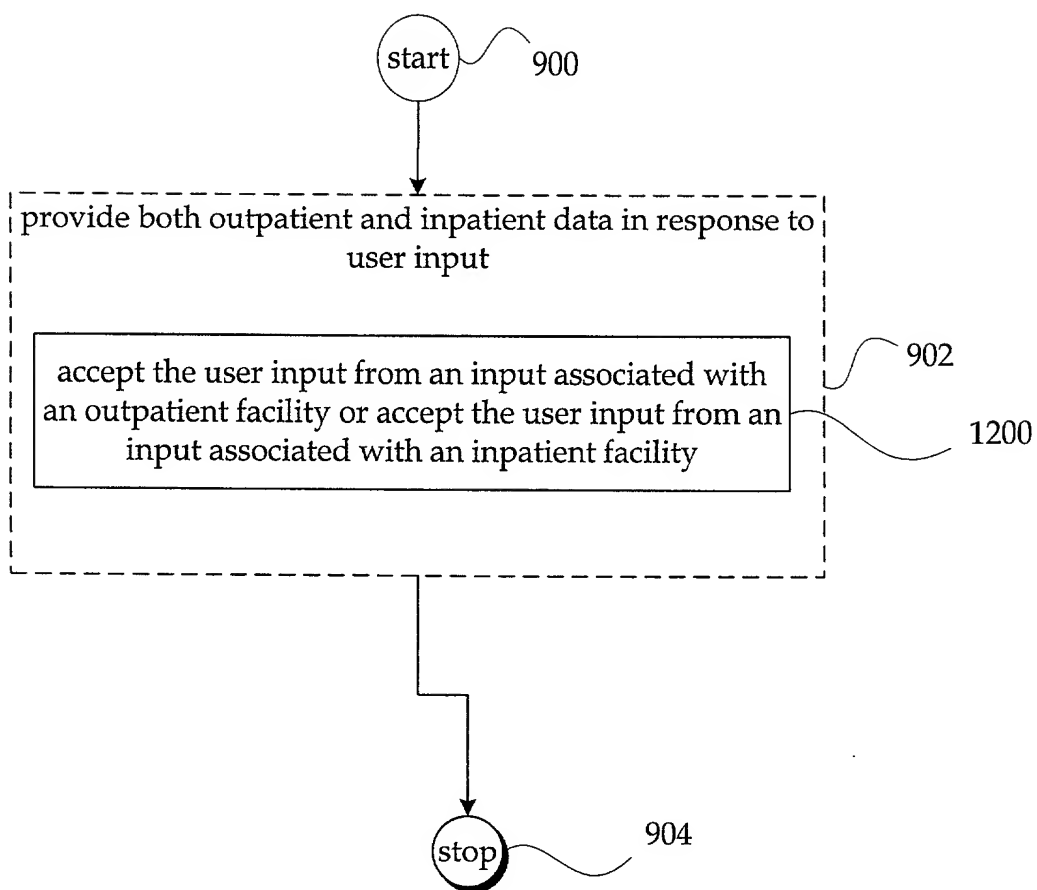


*Fig. 10*

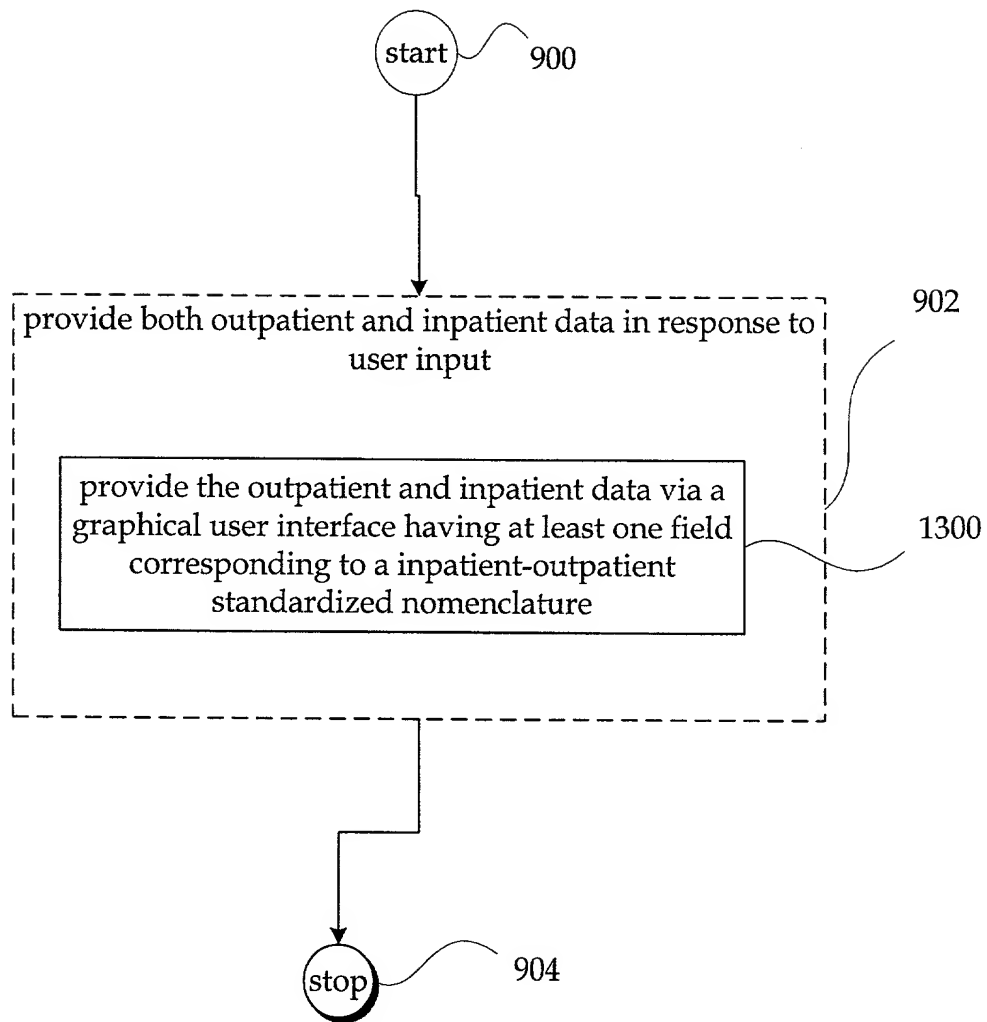


*Fig. 11*

17/55



*Fig. 12*



*Fig. 13*

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cere Exams Demo Tests US Procs Meds Compl Pb List Notes

**Key Information for** Patient Name; Patient SSN **Disposition: PREGNANT**

**UNASSIGNED** Age: 26 G/P: 3/0/0/2/0 EDC: 16 Dec 2001 Gest Age: 38 0/7 Type/Rh: D- **STD LABS ALLERGIES**

Notes Labs Phone Consult Print **Key Information** All Pbs Major Minor Row Height: 100

**Problem List (R = Resolved)**

R	Problem/Condition	Plan (Double click in field to see entire plan)	Comment	Date
	ASTHMA	on Alupent/Azthmacort inhaler prn		02/01
	LATEX ALLERGY	delivery at LRMC	associated with RASH	02/01
	OTHER, SPECIFY		Pt reports allergy to: PCN, Tetracycline, Sulfa,	25/01
	OVARIAN MASS CYSTIC, SPECIFY	L - 9 cm simple cystic mass- transfer from	delivery at LRMC	02/01
	RH NEGATIVE			25/01
	SEIZURE DISORDER, OTHER	Not active	CHILDHOOD ILLNESS	02/01

**Allergies**

Allergy Name	Comment
CLINDAMYCIN	swelling
LATEX	

**Surgical History**

Surgical Procedure	Comment

**Current/Prior Admissions**

**Current Meds (not available yet)**

**Social/Substance History**

Social/Substance Condition	Comment

Note: If some items are not listed and they should be, make sure you have saved all changes on all open screens and then click Refresh. Use the Windows menu option to view a list of open screens.

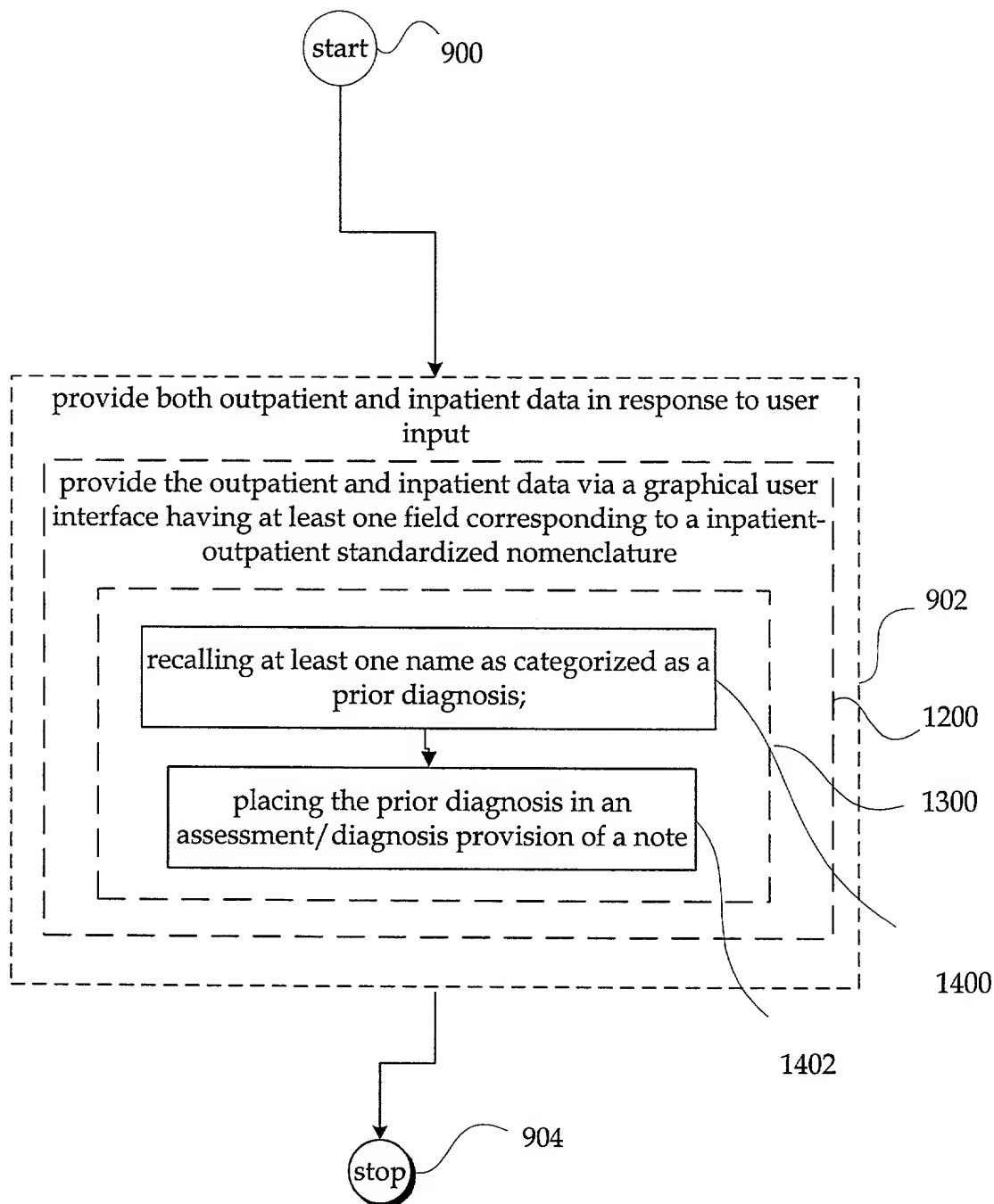
Close Refresh Help

Office

Start Side Sh CHCS CHCS - Inbox STORC RE: L&R Microso...

6:35 AM

Fig. 13A

*Fig. 14*



20030407 21/55

1454

1456

1452

1450

STORE Standard Obstetrics Record Charting System

TRAINING DATABASE

File View Tools Windows Help

Functional Area: OB Clinic

Key Info: General Visit Physical History Care Exams Demo Tests IIS Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name: Patient SSN Disposition: DELIVERED

COMPLICATED Age: 38 G/P: 6/1/13-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/Rh: A- STD LABS NRDA

Detailed OB Visit Information

ROB Visit COB Visit New

Subjective Objective Assessment/Plan

Assessment:

Assessment (Health Condition/Diagnosis)	Pb List	Plan (Db Click)	R/O	Comment
LATEX ALLERGY				
ROB, UNCOMPLICATED				

ROB COB

Patient-Specific Assessment/Plan:

Plans:

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for >= 41 wks	dramann	30 Nov 2001 1500	

Add Plan Delete Stop

Patient-Specific Plans:

Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2x/wk. Consider induction.

CHRONIC CONDITIONS WERE ADDED View Existing Notes OK Cancel Reset Help

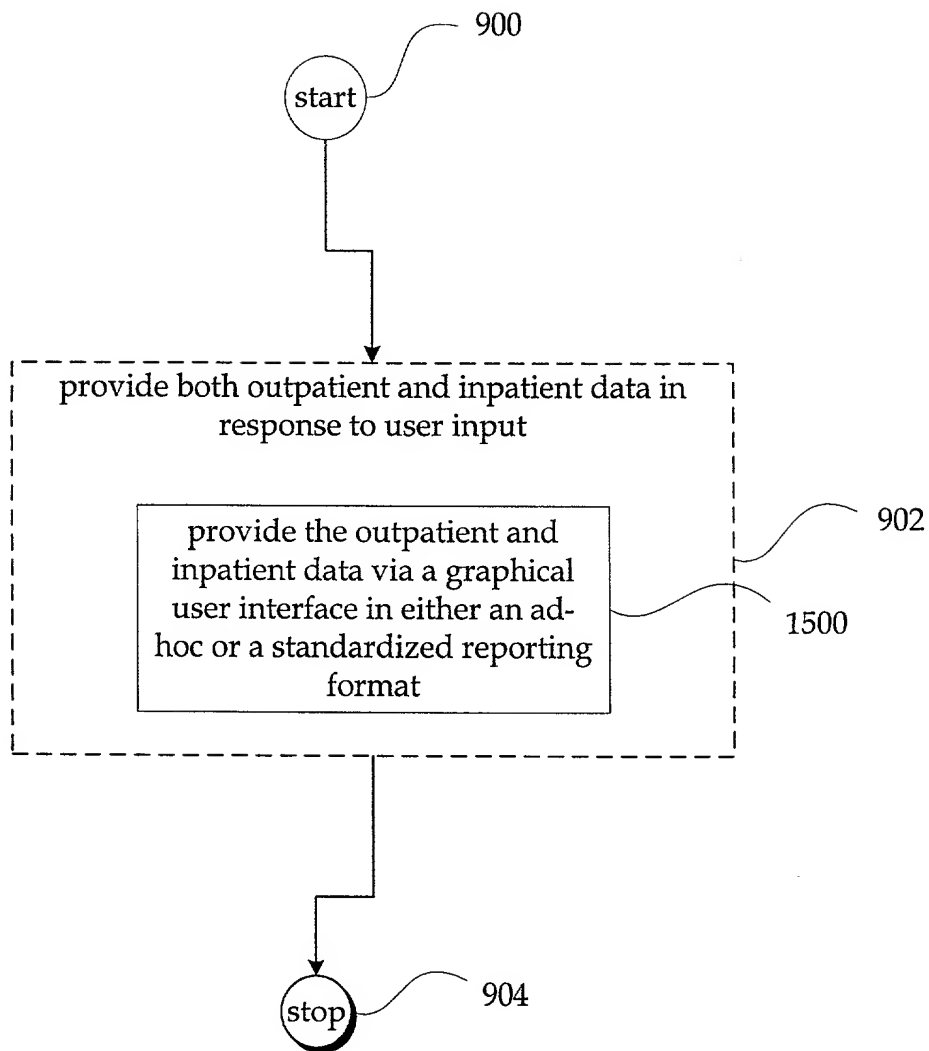
Microsoft Office

Start Slide Show Print Info Help CHC CHC FV RE Microsoft Word - Document5 2:46 PM

Fig. 14A

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

22/55



*Fig. 15*

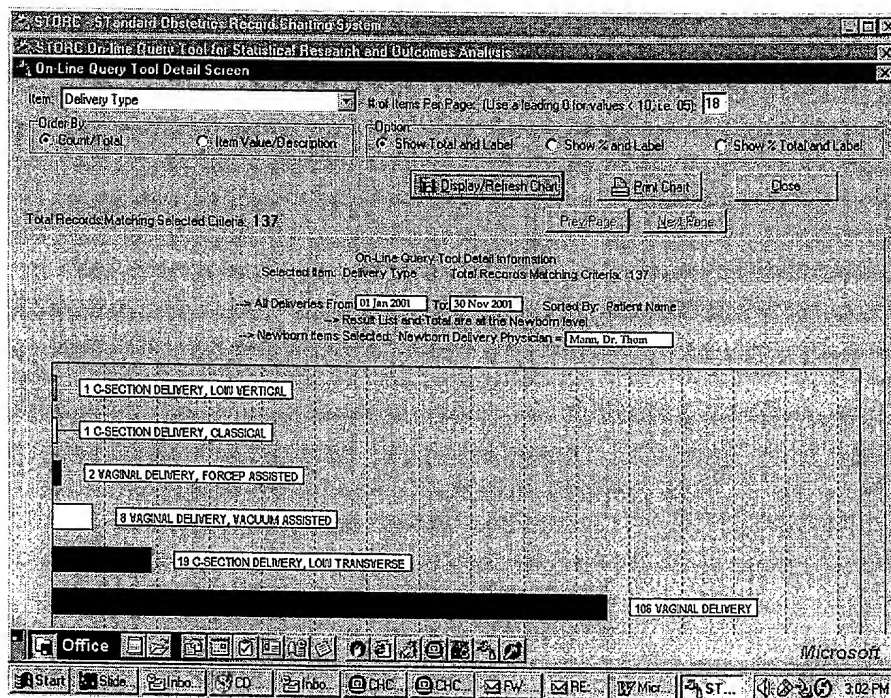
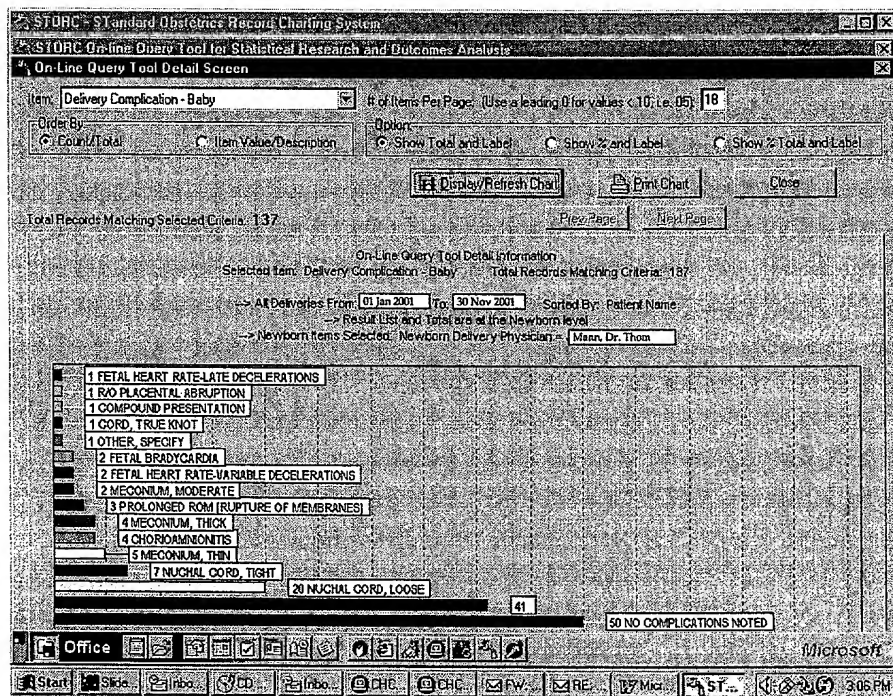


Fig. 15A

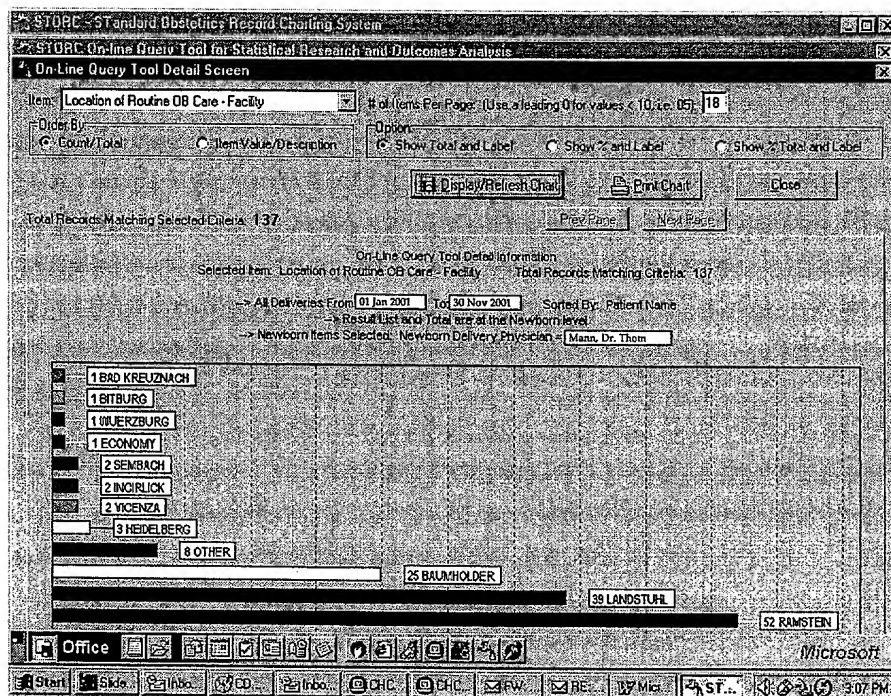
ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL



1570

1572

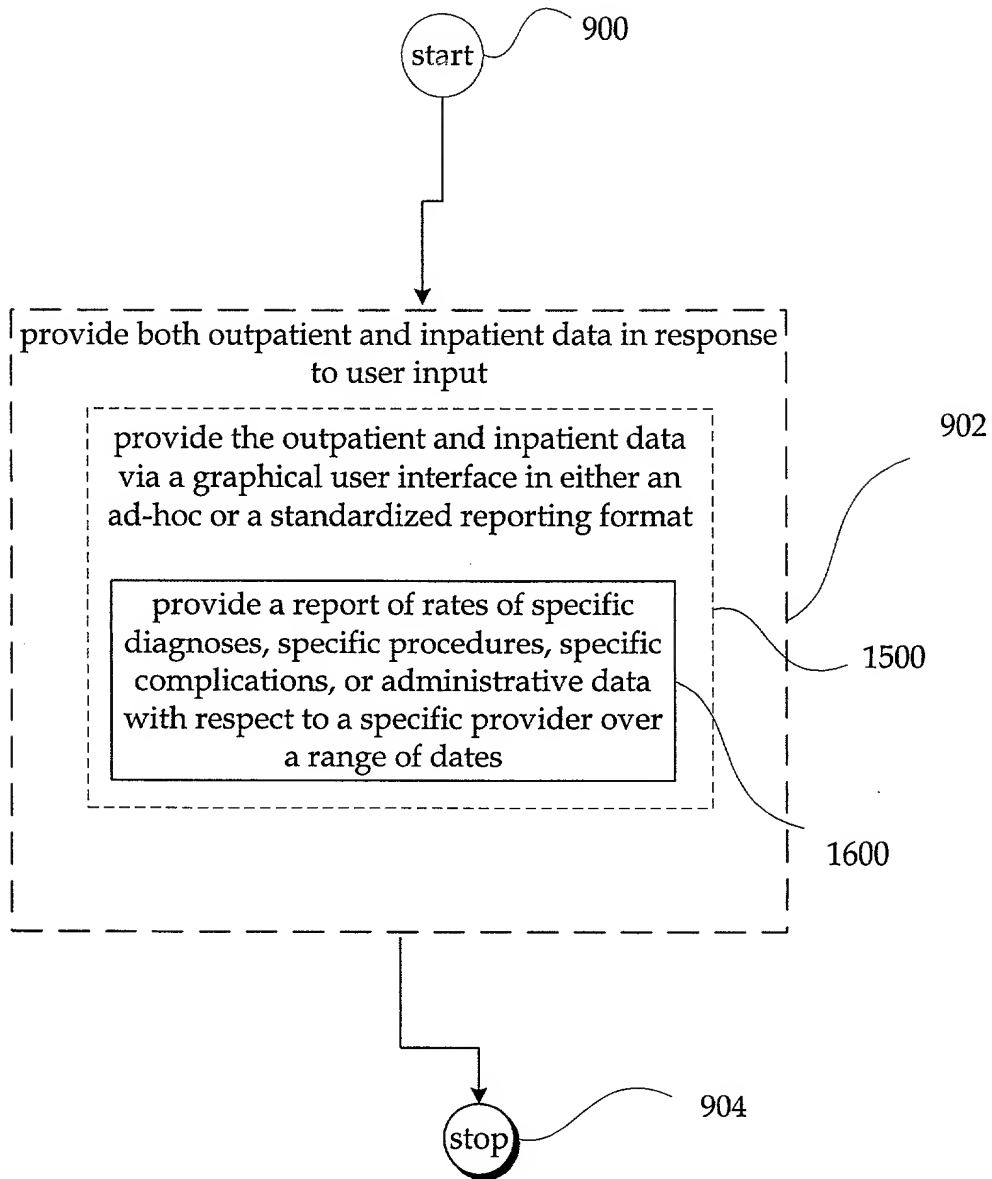
Fig. 15B



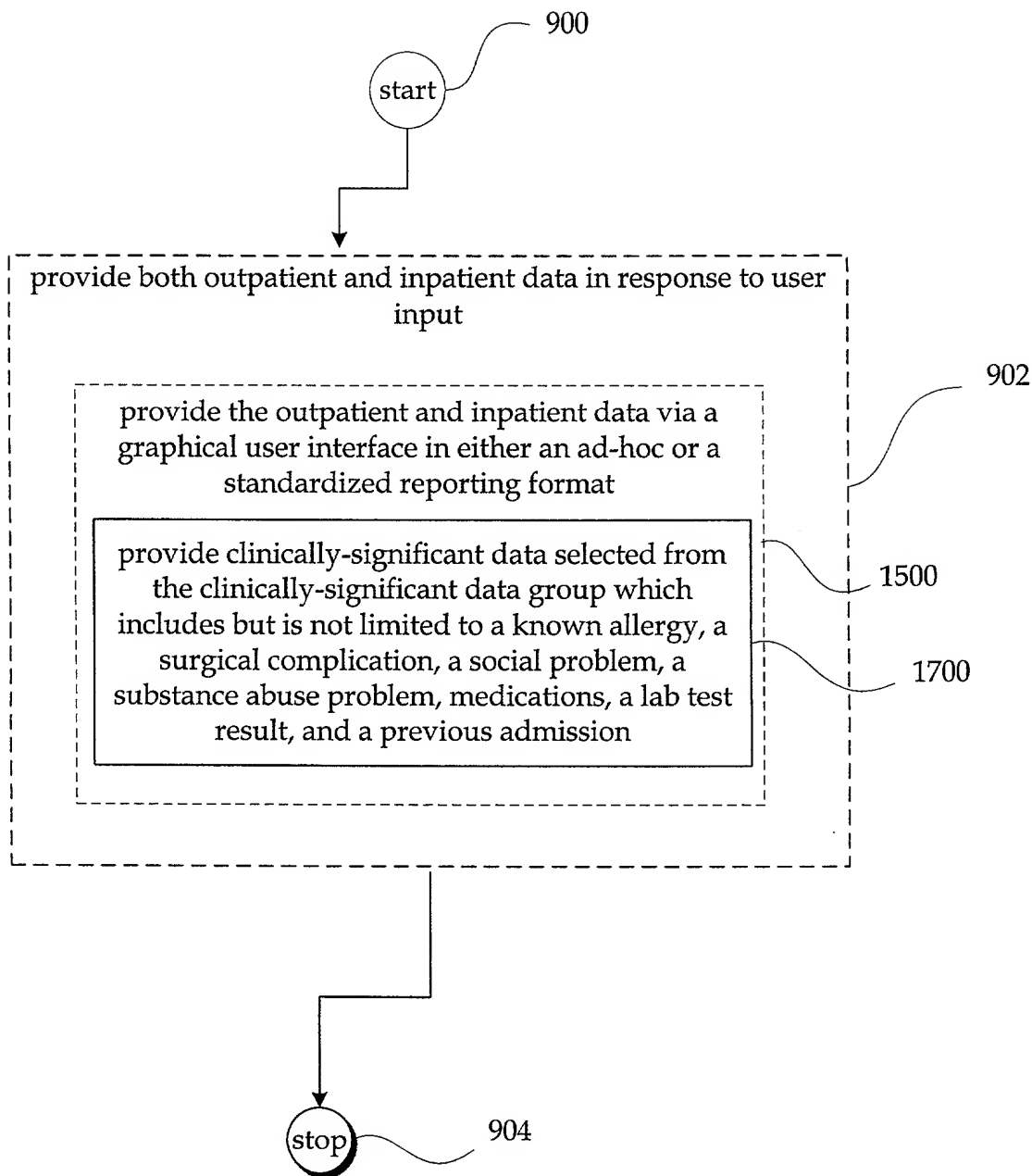
1580

1582

Fig. 15C

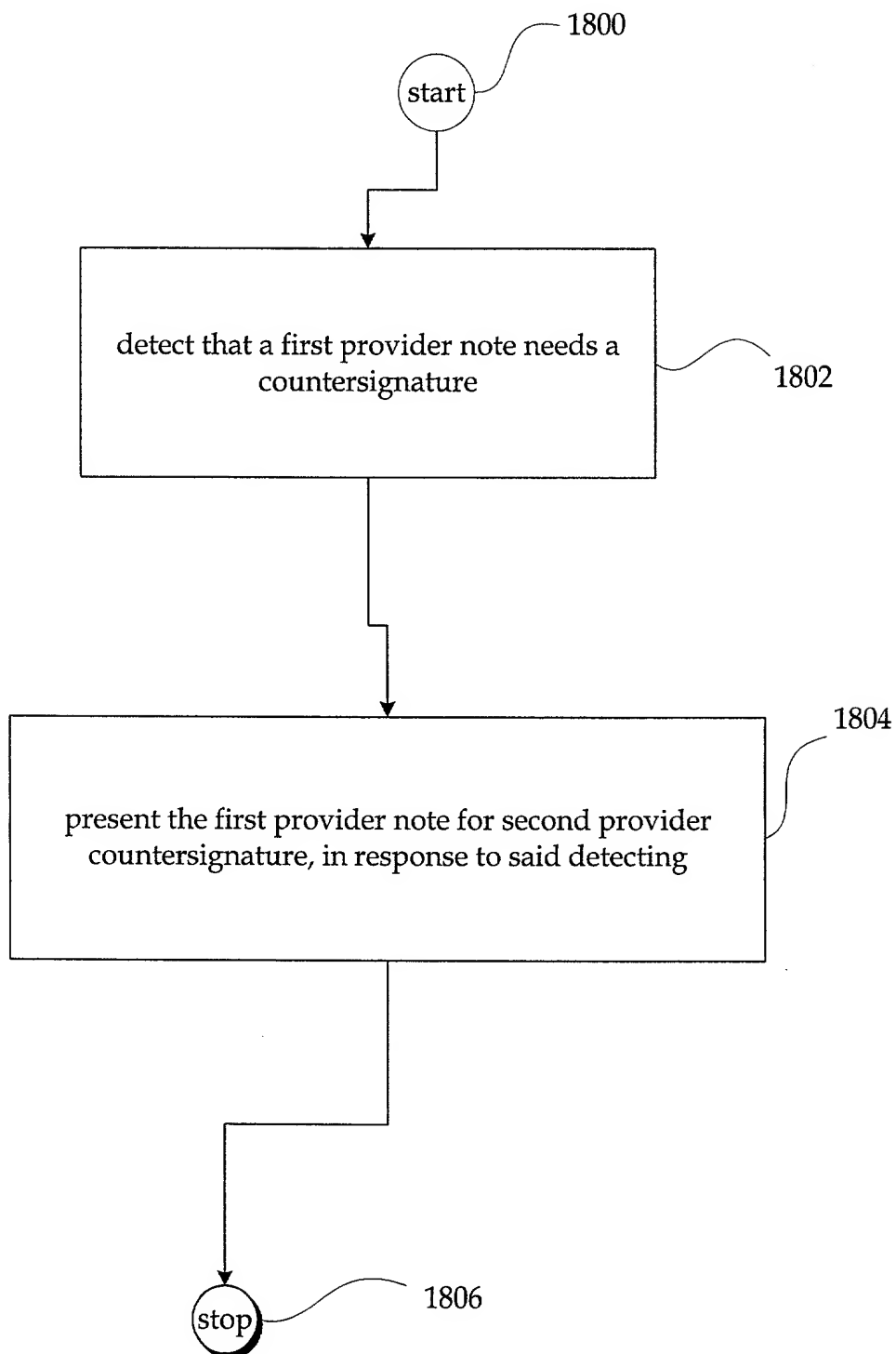


**Fig. 16**



*Fig. 17*

28/55



*Fig. 18*



29/55

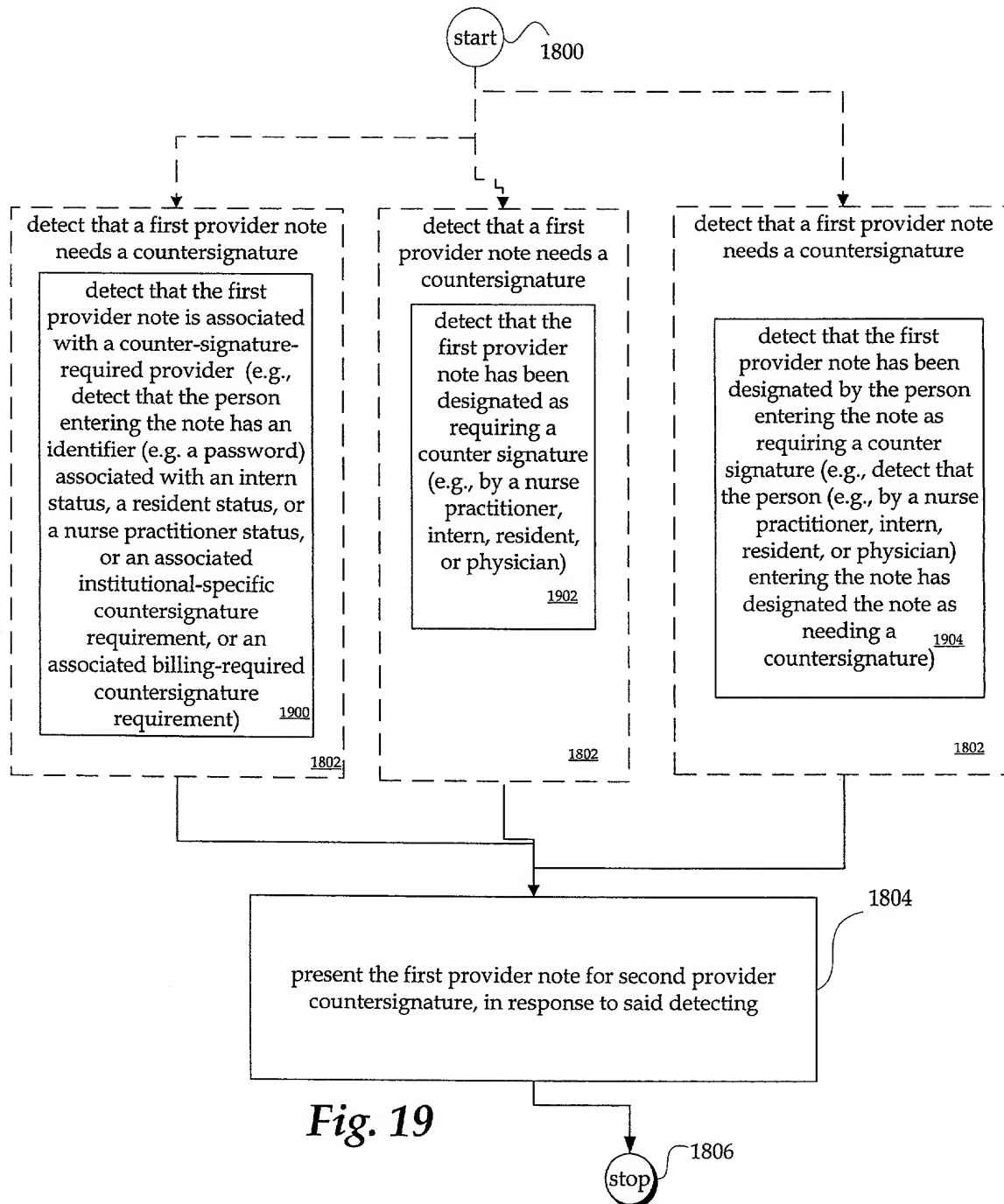


Fig. 19

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Proc Meds Compl Pb-List Notes

**Progress Notes for** Patient Name; Patient SSN Disposition: PREGNANT

**UNASSIGNED** Age: 32 G/P: 1/0-0-0-0 EDC: 30 Feb 2002 Gest Age: 26 6/7 Type/Rh: A+ **STD LABS ALLERGIES**

Assoc. Visit/Encounter: ROUTINE OB

New Phone Call/Consult: 17 Nov 2001 0800

**Progress Notes** View Existing Notes...

Progress Note Category: ANTEPARTUM NOTE Provider to Review Note: Doe, John A. Date the Note is for: [optional] Time: [optional]

**Standard Note** Free Text/Addendum to Standard

Blank/Addendum Text

Test note.

Next

(Note: To clear the date, click in the field and press the Delete key.)

Critical?

☐ Yes ☒ No

Type

☐ Inpatient ☒ Outpatient

View Entire Note... Save/Close Save Cancel Reset Help

Office

Microsoft

Start Slide Inbo CD Inbo CHC CHC FW RE Mbr ST...

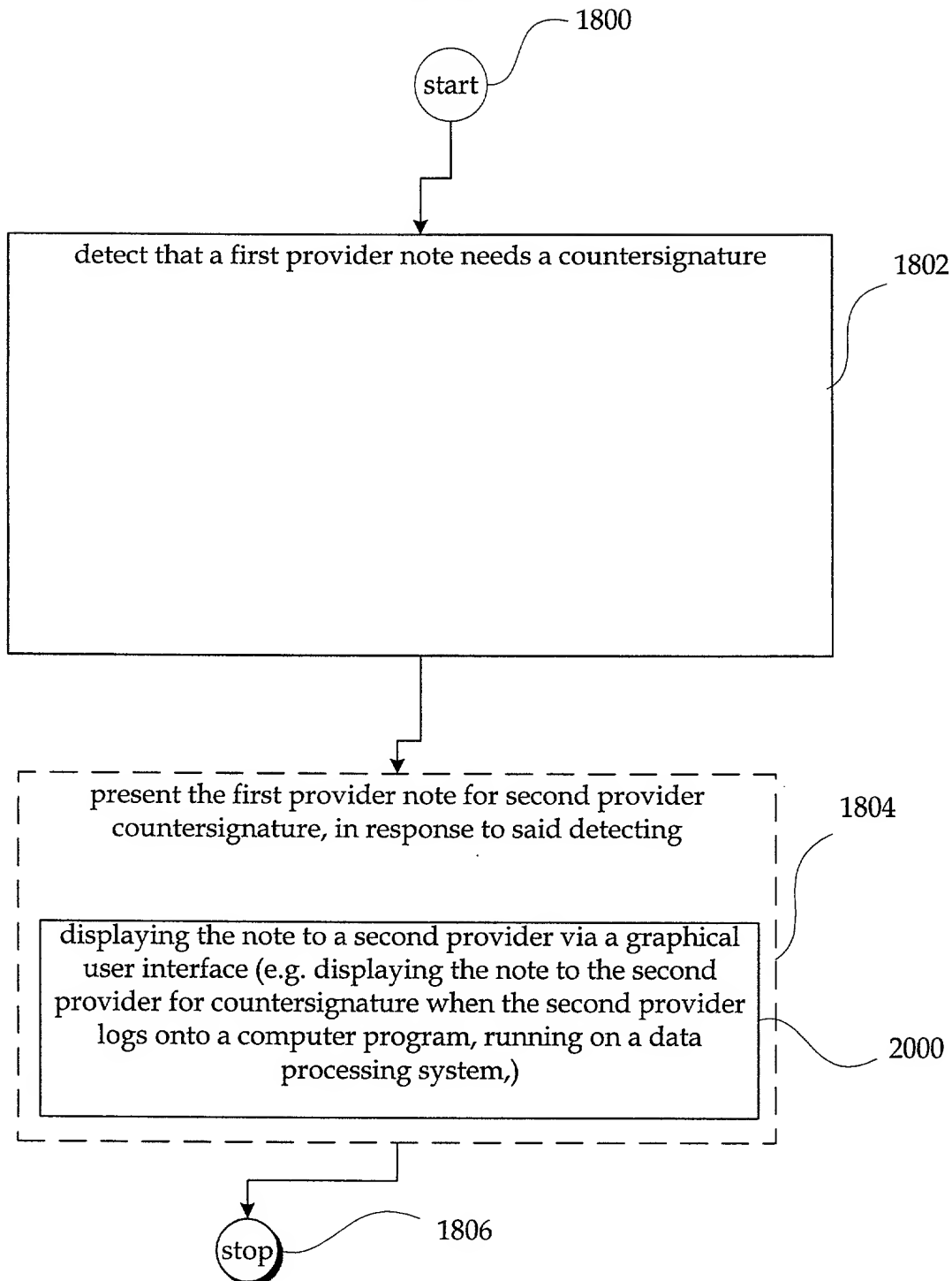
3:34 PM

1950

1952

Fig. 19A

31/55



*Fig. 20*

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

**Open Patient Chart**

**A. Search Criteria**

☐ 1. Specific Patient: Last Name:  Primary Care Facility:  For this Specific Patient option, include:
   
☐ 2. All current patients with risk:  IF in OB Care: 
☐ Current pregnancies only
   
☐ 3. Patients who have not delivered, but are admitted to: 
☐ All pregnancies
   
☐ 4. Patients who have delivered, but have not been discharged
   
☐ 5. Patients who have been discharged, but still need follow-up phone call
   
☐ 6. Patients who delivered on:  to: 
☐ 8. Patients who have NOTES to be reviewed by: 
  
☐ 7. Patients seen from:  to:  by: 
☐ 9. Patients who have ITEMS to be reviewed by:

Search Reset Print

**B. Search Results**

P	Patient Name (Last, First MI)	FMP	Sponsor SSN	Grav	Para	Wks	Days	EDC Date	Delivery Date	Discharge Date	Discha
	Doe, Jane A.	20	111-11-111	1	0	38	0	06 Dec 2001	23 Nov 2001	25 Nov 2001	0900
	Doe, Jane B.	20	222-22-222	1	0	35	1	03 Jan 2002			
	Doe, Jane C.	20	333-33-333	1	0	19	6	20 Apr 2002			
	Doe, Jane D.	20	444-44-444	1	0	24	5	14 Mar 2002			

P = Physician Review for Delivery Info (\* = Needs to be reviewed)

Total patients matching search criteria: 4

Office

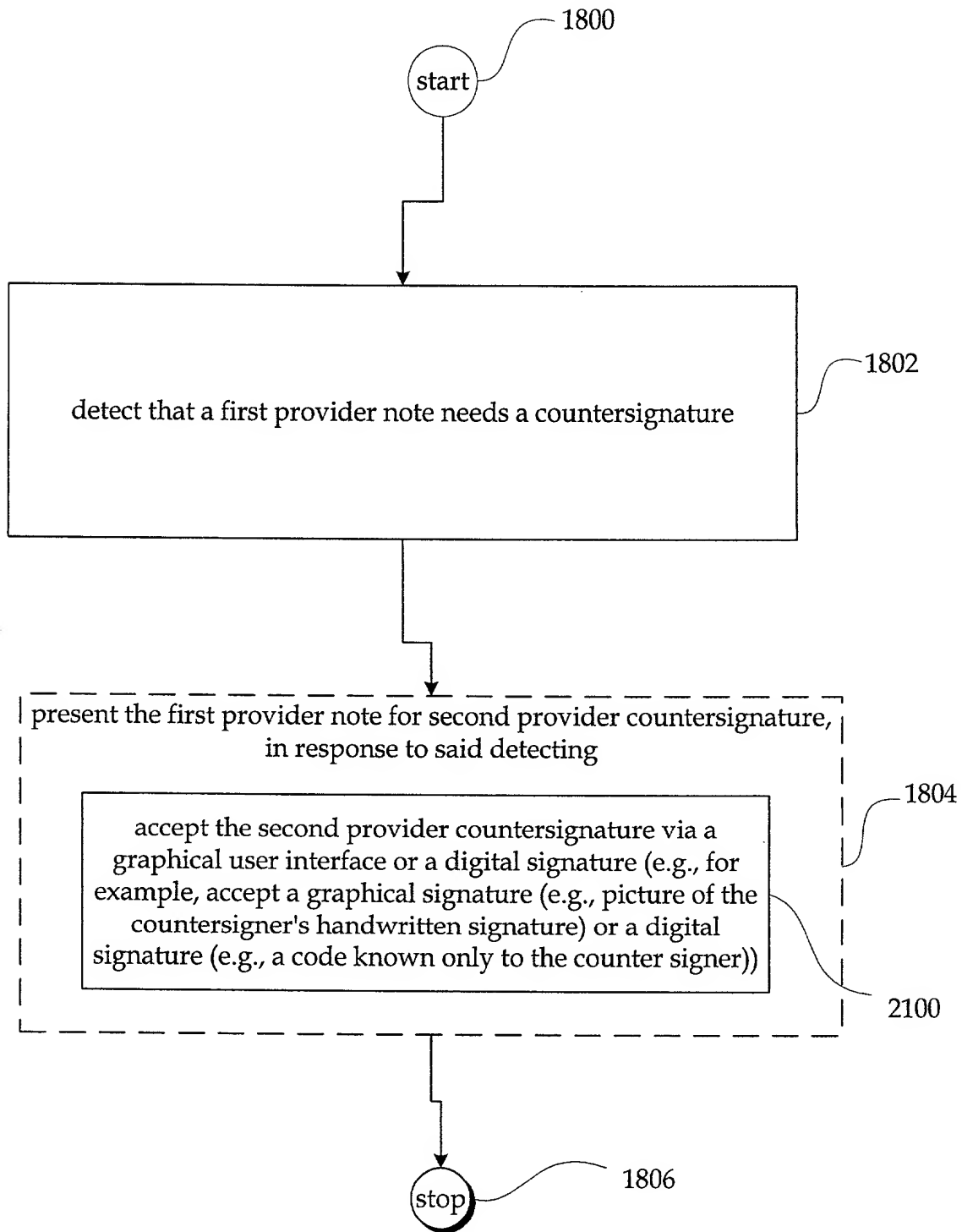
Microsoft

Start Slide ... Inbox ... CD PL ... STORC ... Inbox ... CHCS ... CHCS ... FW: C ... RE: S ... 1:55 PM

2050

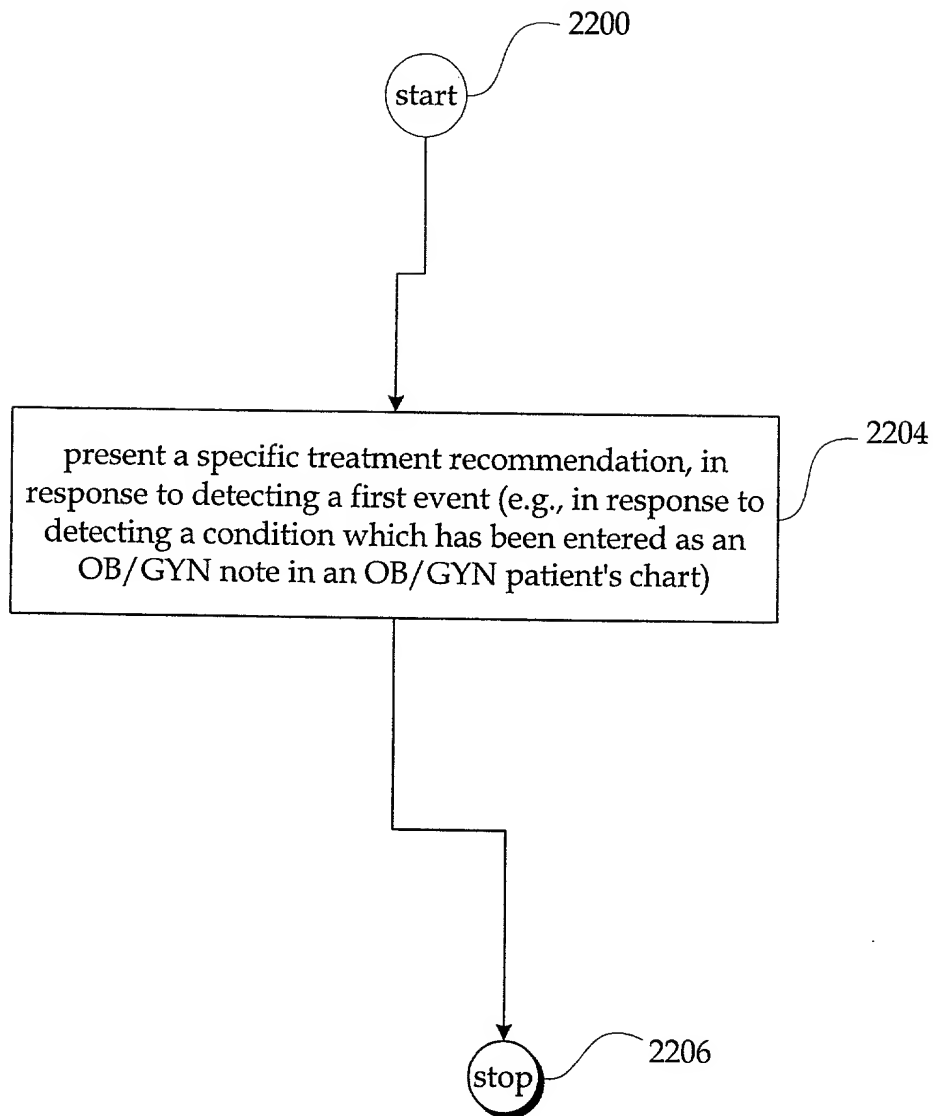
2052

Fig. 20A



*Fig. 21*

34/55



*Fig. 22*

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info: General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: PREGNANT

LOW Age 20 G/P 2/0/0/1/0 EDC 08 Mar 2002 Gest Age 17 1/7 Type/Bt D+ STD LAES NKDA

Detailed OB Visit Information

Subjective Objective Assessment/Plan

ROB Visit COB Visit Next

Assessment

Assessment (Health Condition/Diagnosis)	Pb List	Plan (Dbl Click)	R/O	Comment
OBESITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MASTITIS, PREGNANCY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Specific Assessment(s)

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for 15 - 19 wks	draumann	17 Nov 2001 1408	

Add Plan Delete

Patient-Specific Plan(s):

Offered Triple Screen, RTC in 4-6 weeks, Note quickening.  
RX with Dicloxacillin.

View Existing Notes OK Cancel Reset Help

Office

Start Std Inba CD Inba CHC CHC FW RE BY Mic ST 3:26 PM

2254

2250

2256

Fig. 22A

2252

STORC: Standard Obstetrics Record Charting System

File View Tools Windows Help

Key Info General Visits Physical History Cerv Exam Deno Tests US Procs Meds Compl Pb List Notes

ROB/CDB Detailed Visit Information for Patient Name; Patient SSN Disposition: PREGNANT

UNASSIGNED Age 37 G/P 3/1-0-1-4 EDC 08 Mar 2001 Gest Age 31-9/7 Type/Rn B STD LABS NKDA

### Detailed OB Visit Information

Subjective Objective Assessment/Plan ROB Visit CDB Visit Next

**Assessment**

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/O?	Comment
ADVANCED MATERNAL AGE	<input type="checkbox"/>		<input type="checkbox"/>	
ANEMIA	<input type="checkbox"/>		<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>		<input type="checkbox"/>	

Patient-Specific Assessment(s)

**Plans**

Standard Plan/Remark	Entered By	Entered Date	Day
Standard Plan for > 28 wks and < 36 wks	Idrmann	24 Nov 2001	1103

Patient-Specific Plan(s)

Preterm Labor Precautions, RTC in 2 weeks, Daily Fetal Kick Counts recommended, Breast feeding class encouraged, Signs/symptoms of preeclampsia reviewed, Preadmit if not yet done.

View Existing Notes OK Cancel Reset Help

Office

Microsoft

Start Stop Info CD Info CHC CHC FW RE My Mic ST... 3:12 PM

2254

2250

2256

Fig. 22B



37/55

2252

STORC: Standard Obstetrics Record Chaining System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Carv Exams Demg Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: ADMITTED

COMPLICATED Age 22 G/P 120-0-00 EDC 19 Mar 2001 Gest Age 41 Wk 7 Type/Rh: A- STD LABS ALLERGIES

### Detailed OB Visit Information

Subjective Objective Assessment/Plan ROB Visit COB Visit New

**Assessment:**

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (DB Click)	R/O?	Comment
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CARDIAC DISEASE, SPECIFY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recommended right arm and right leg B/Ps each visit
RH NEGATIVE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ROB, UNCOMPLICATED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient-Specific Assessment(s)

**Plans**

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for >= 41 wks	drmann	27 Nov 2001 1012	

Patient-Specific Plan(s): Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2X/wk, Consider induction.

View Existing Notes OK Cancel Reset Help

Office Start Skd Inbo CD Inbo CHC CHC PW RE ST... 3:27 PM

2254

2250

2256

Fig. 22C

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

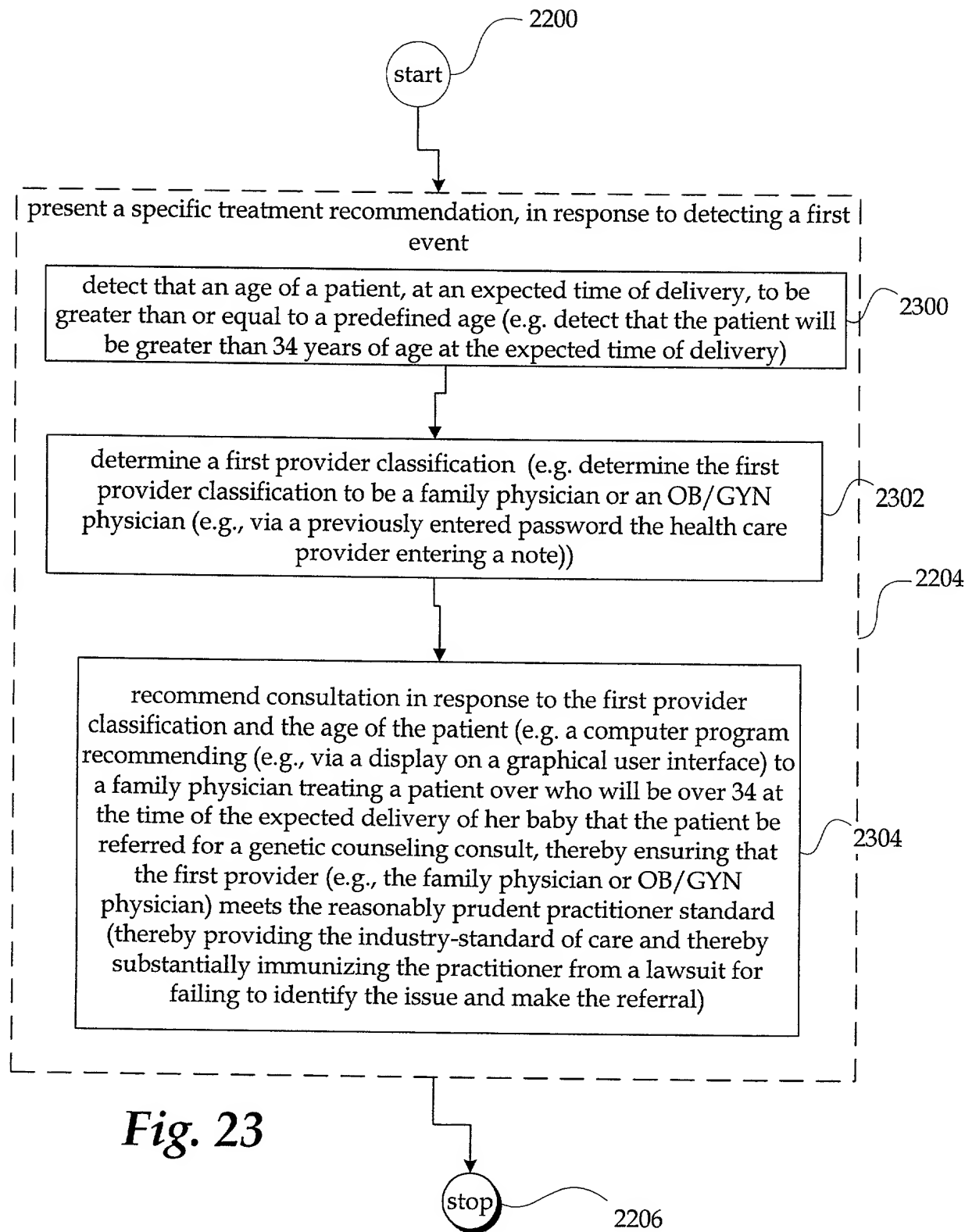


Fig. 23

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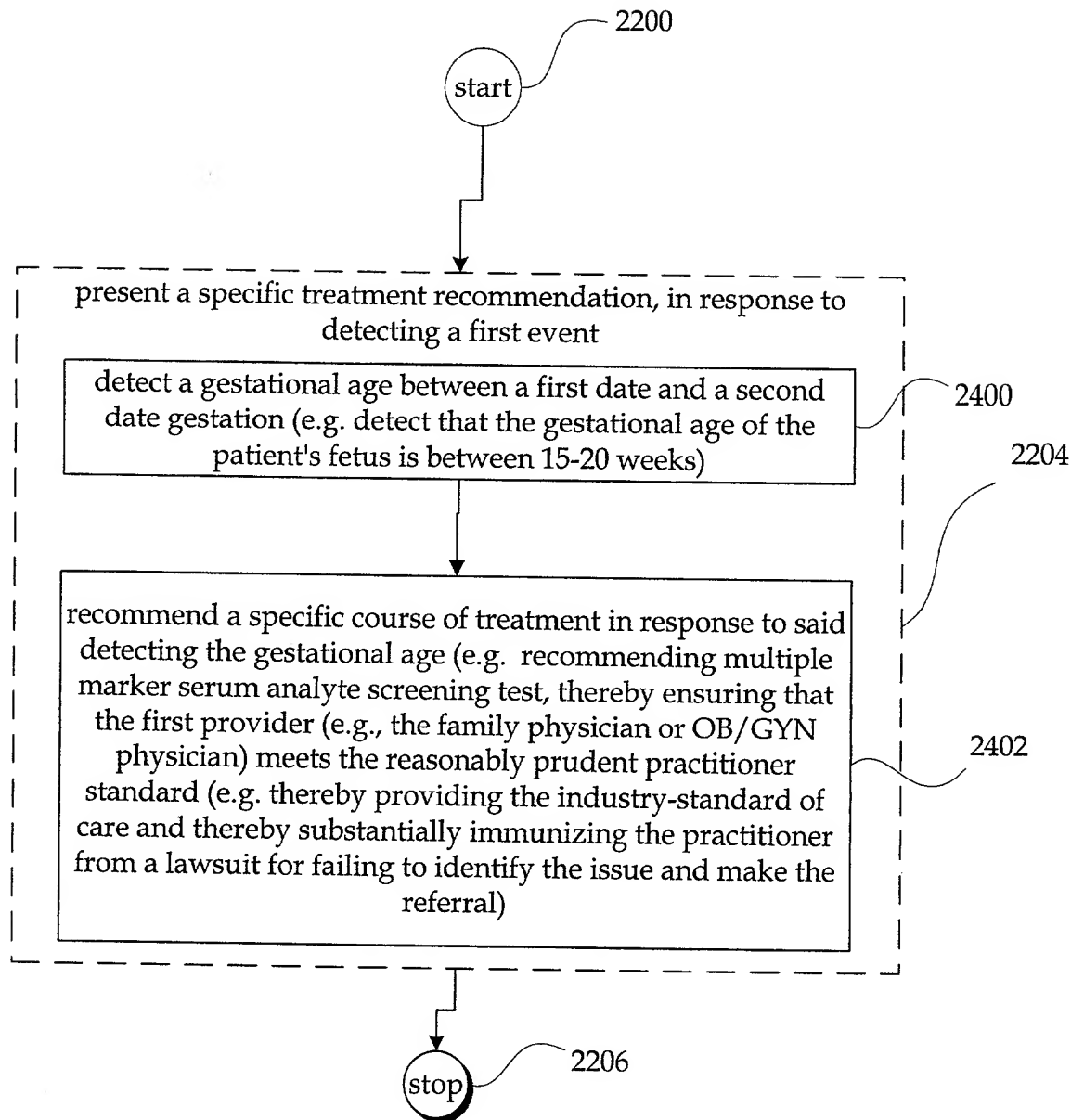


Fig. 24

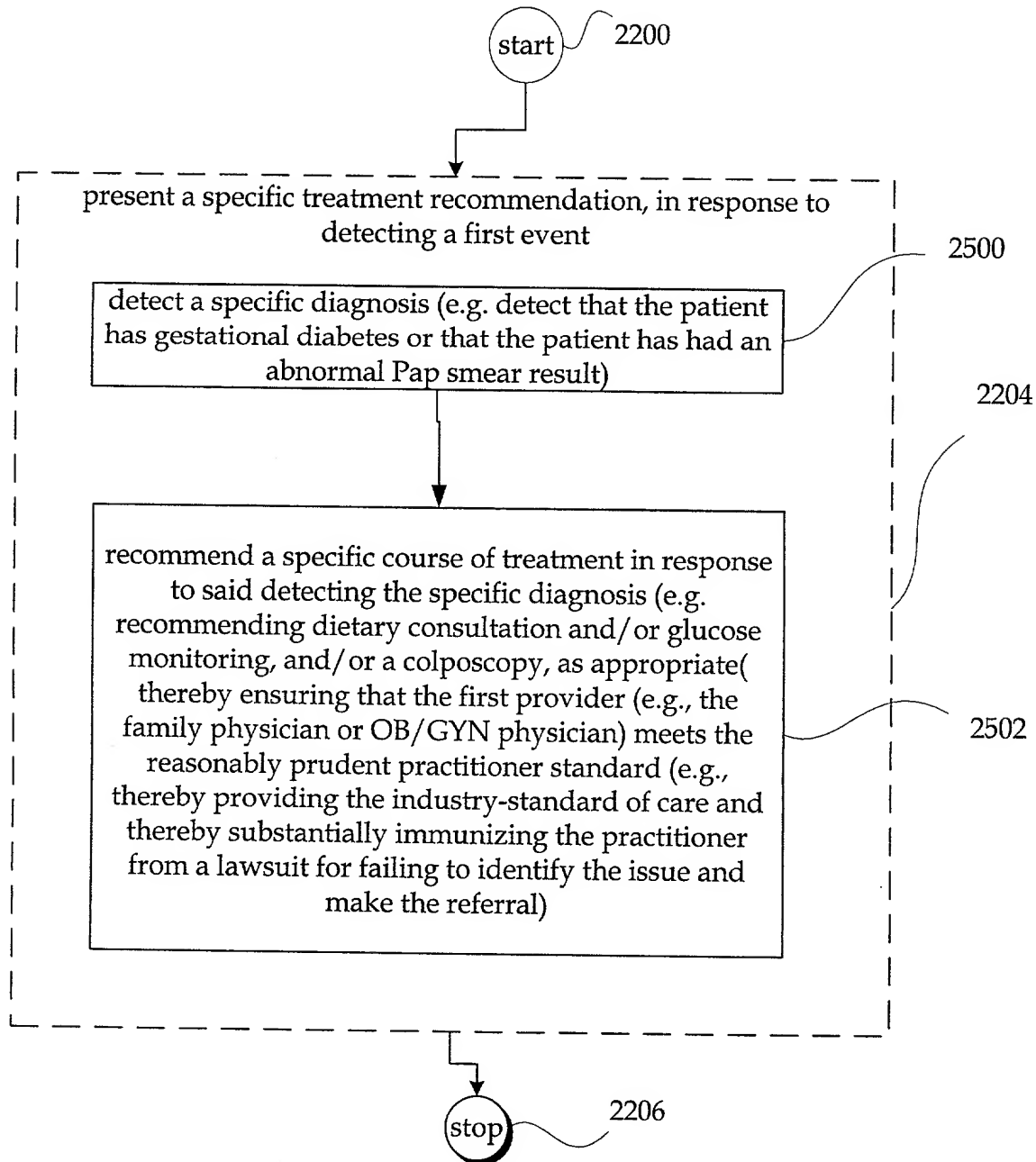
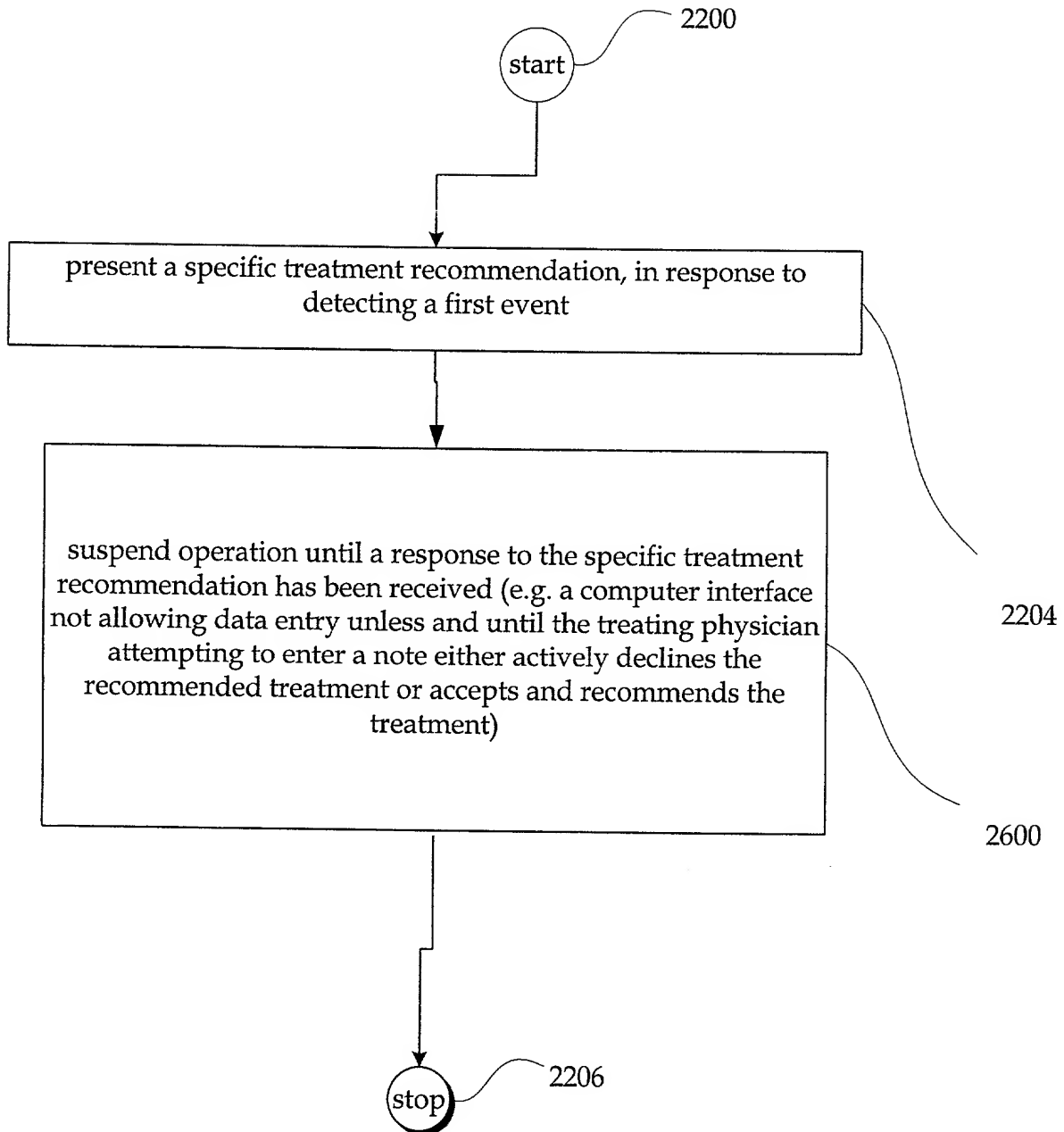
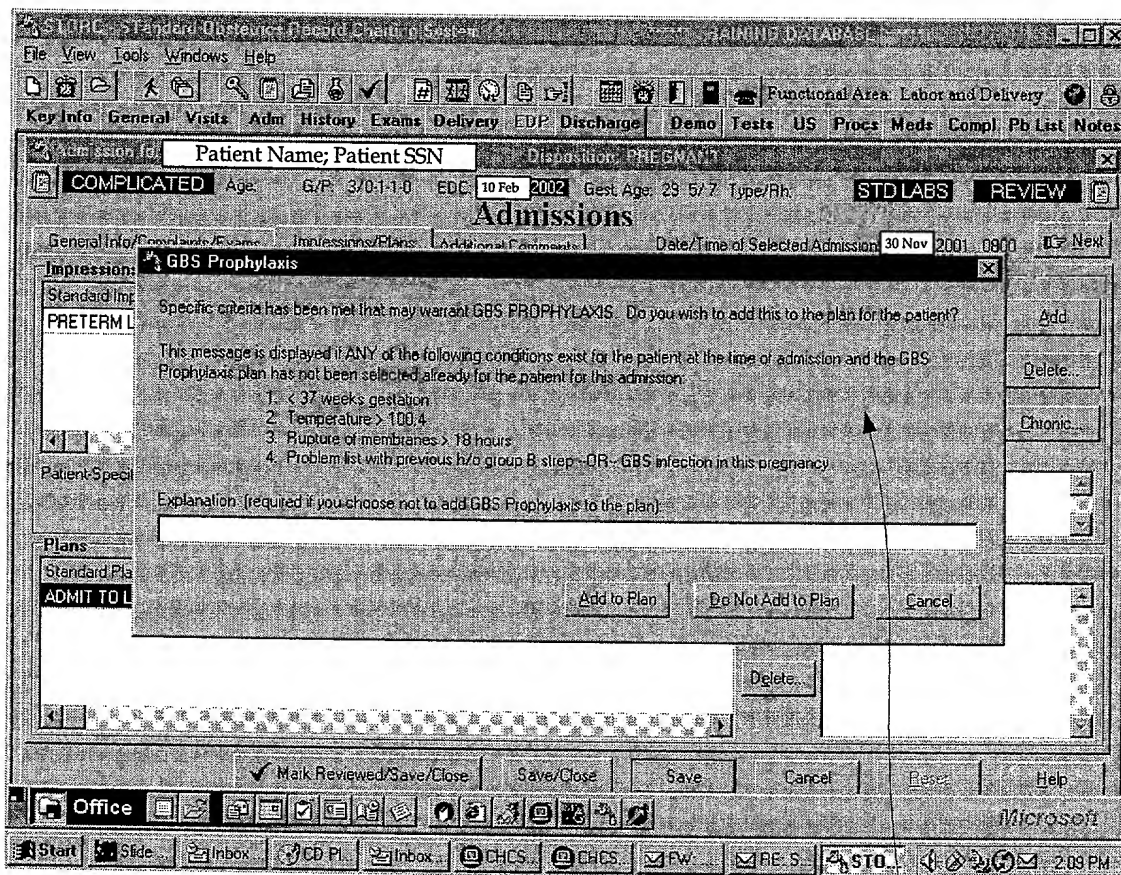


Fig. 25

*Fig. 26*

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2650

2652

Fig. 26A

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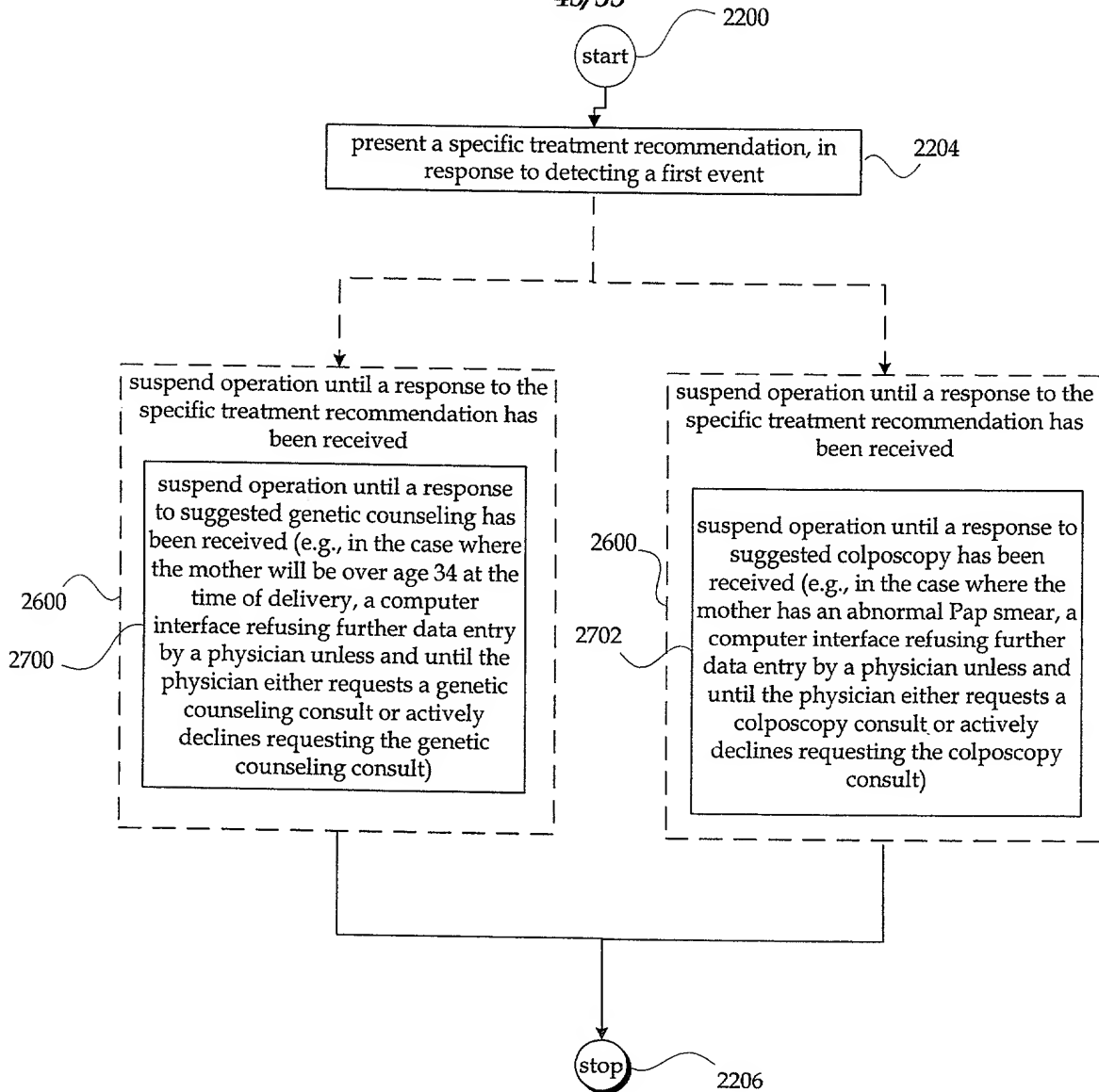
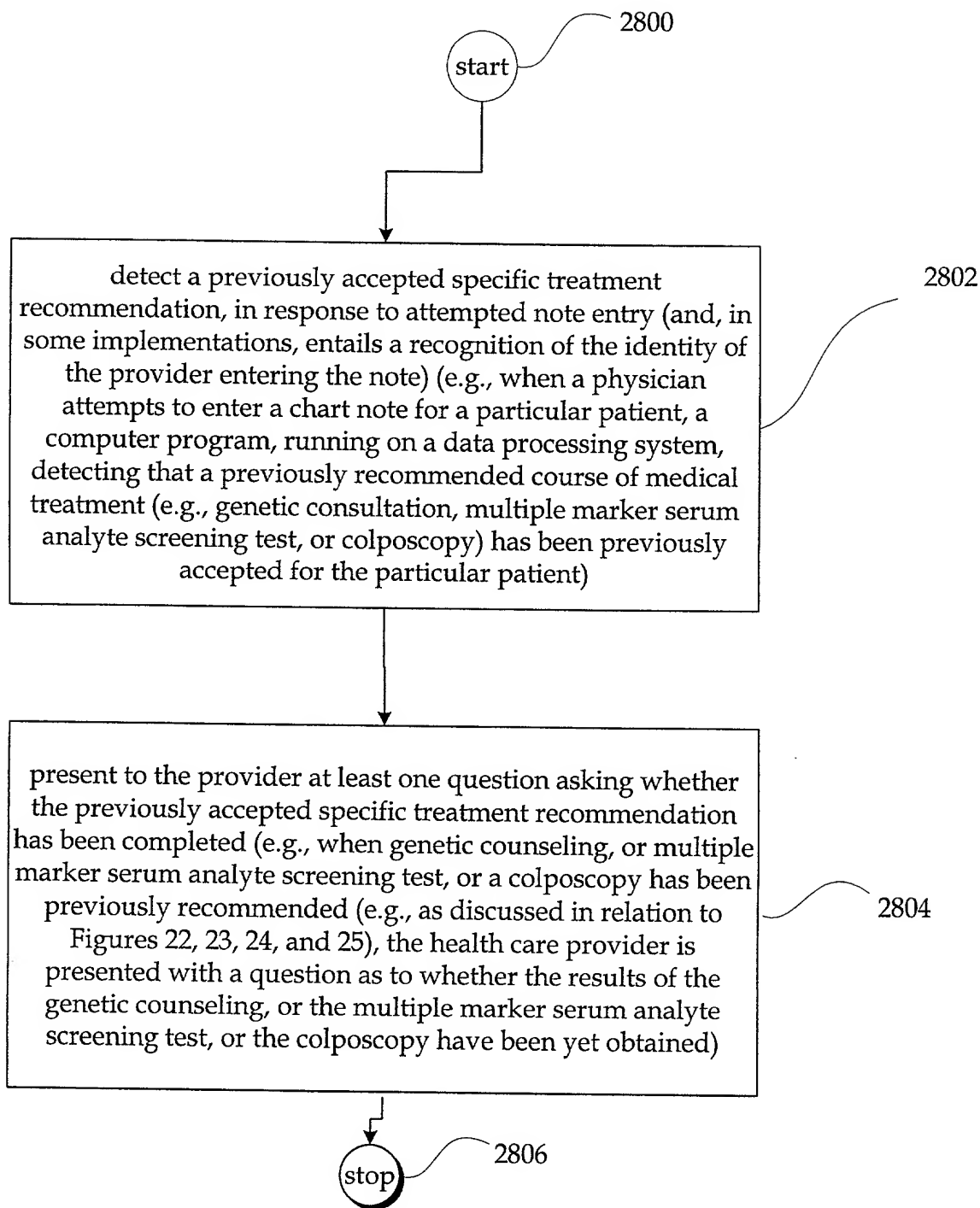
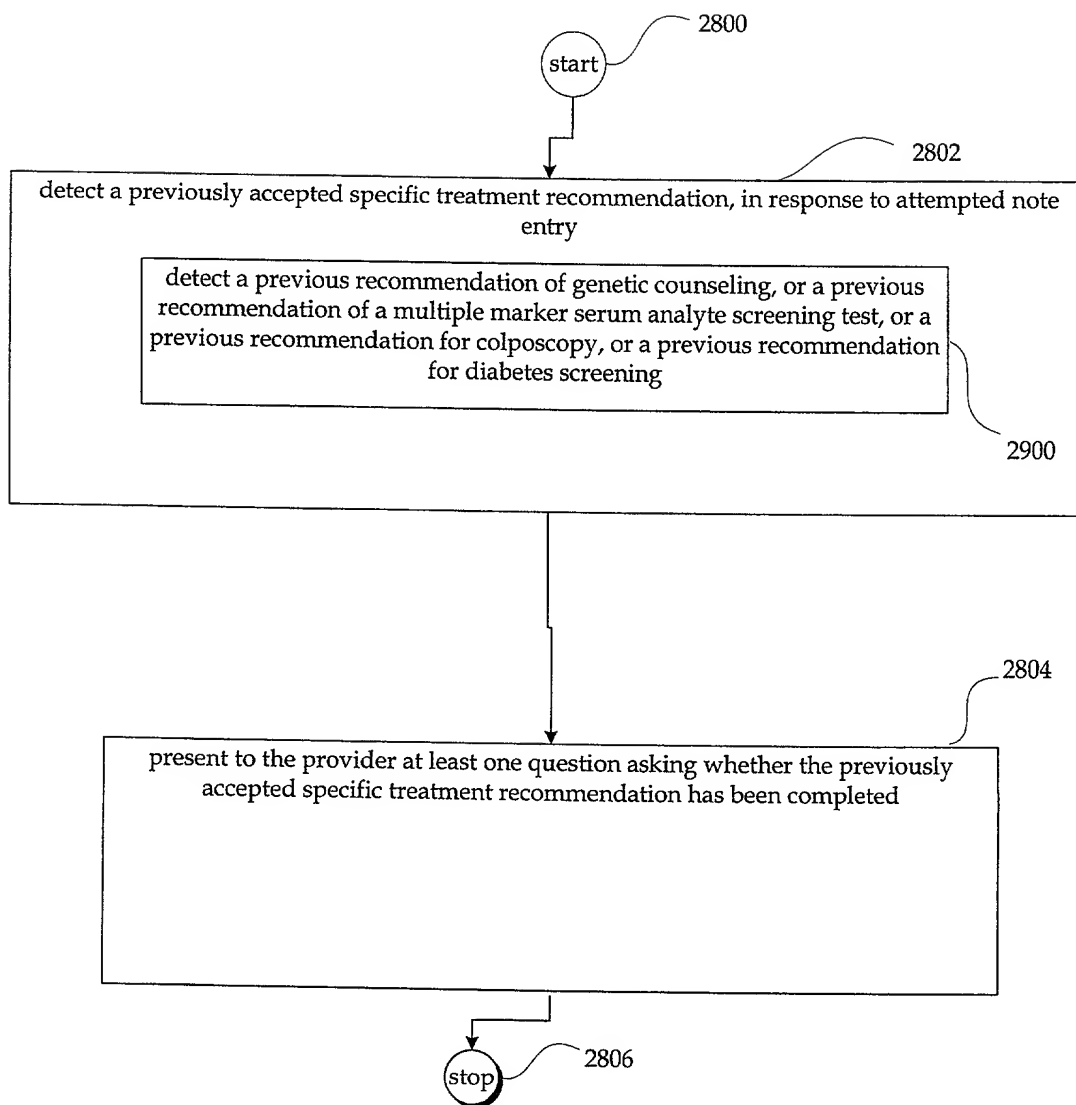


Fig. 27

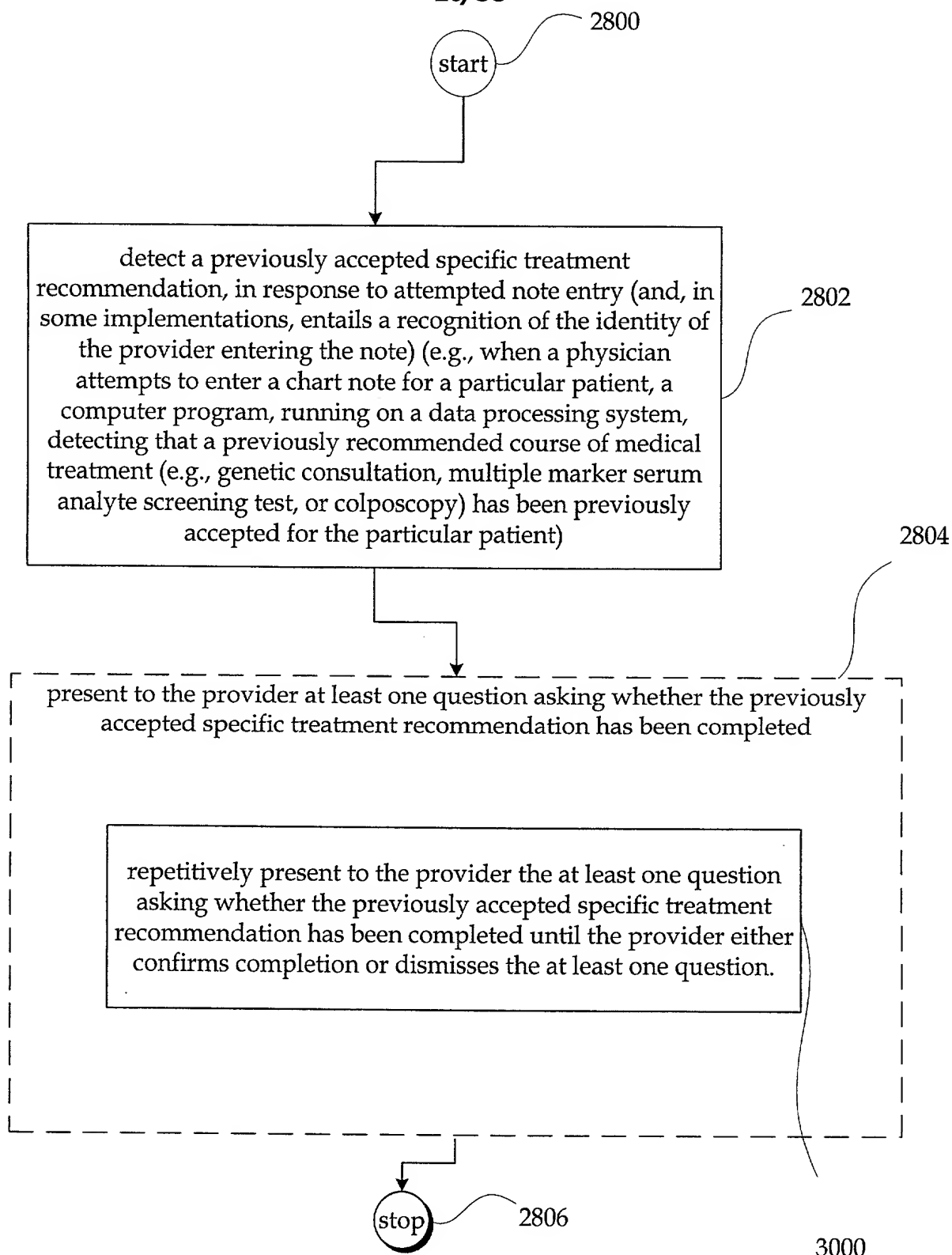


*Fig. 28*



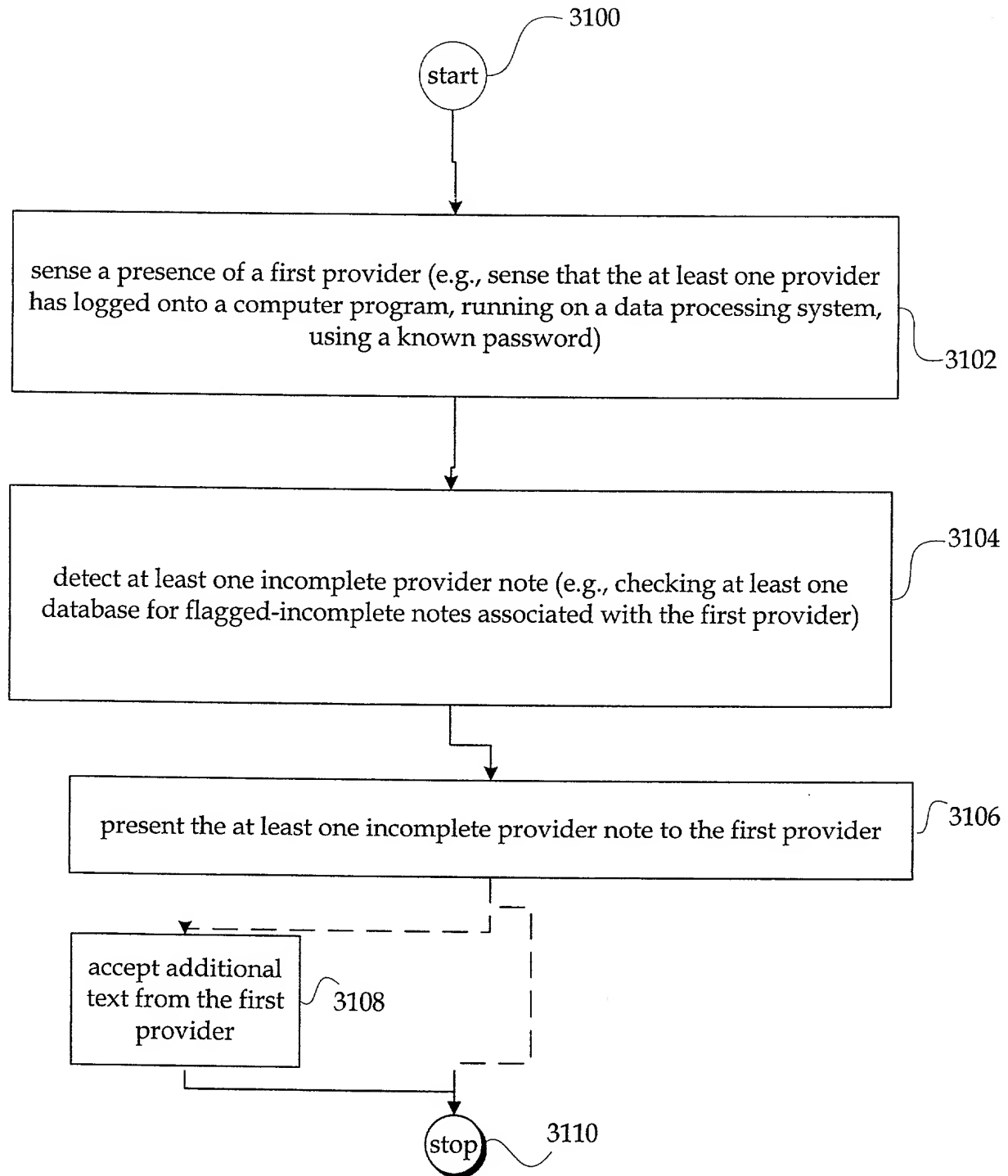
*Fig. 29*

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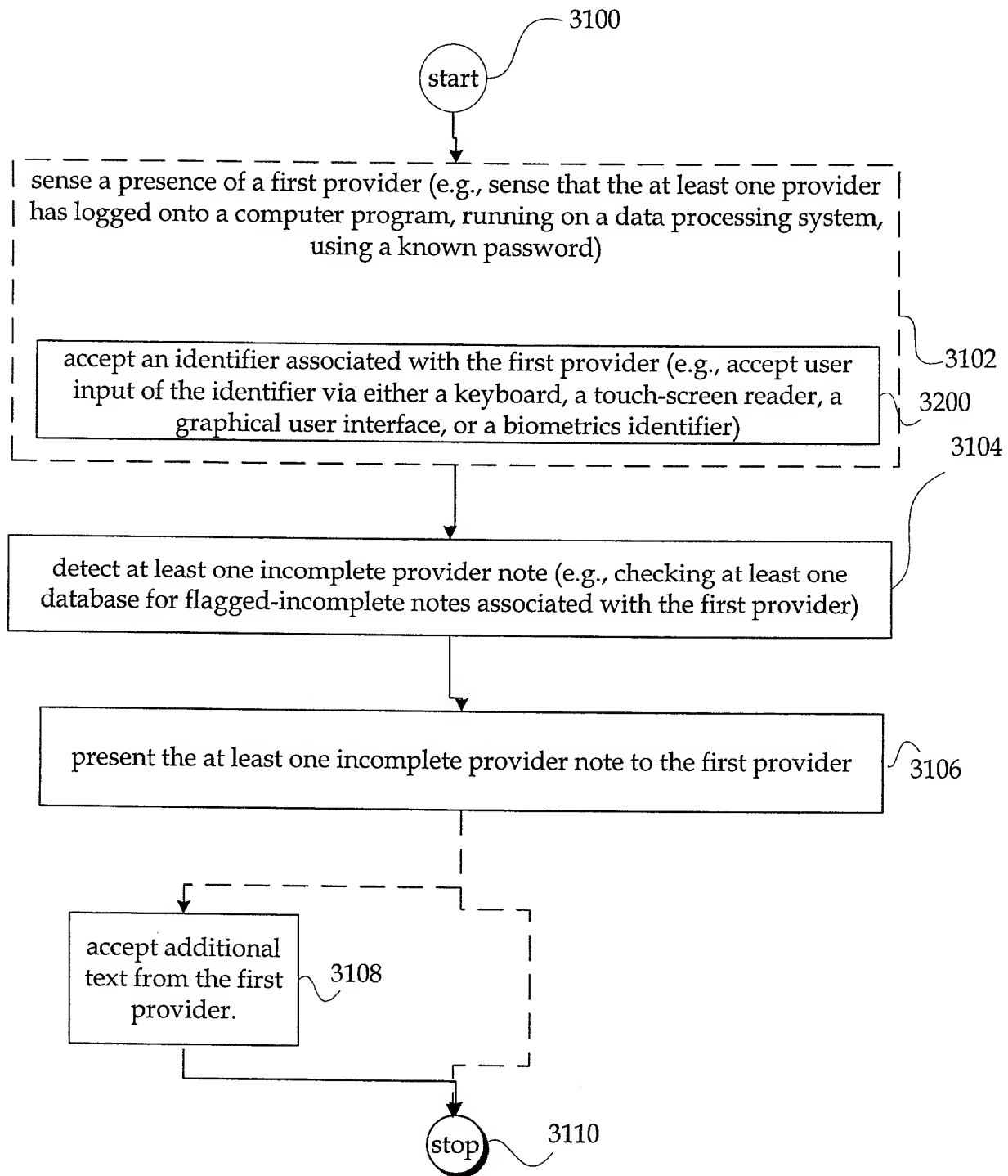


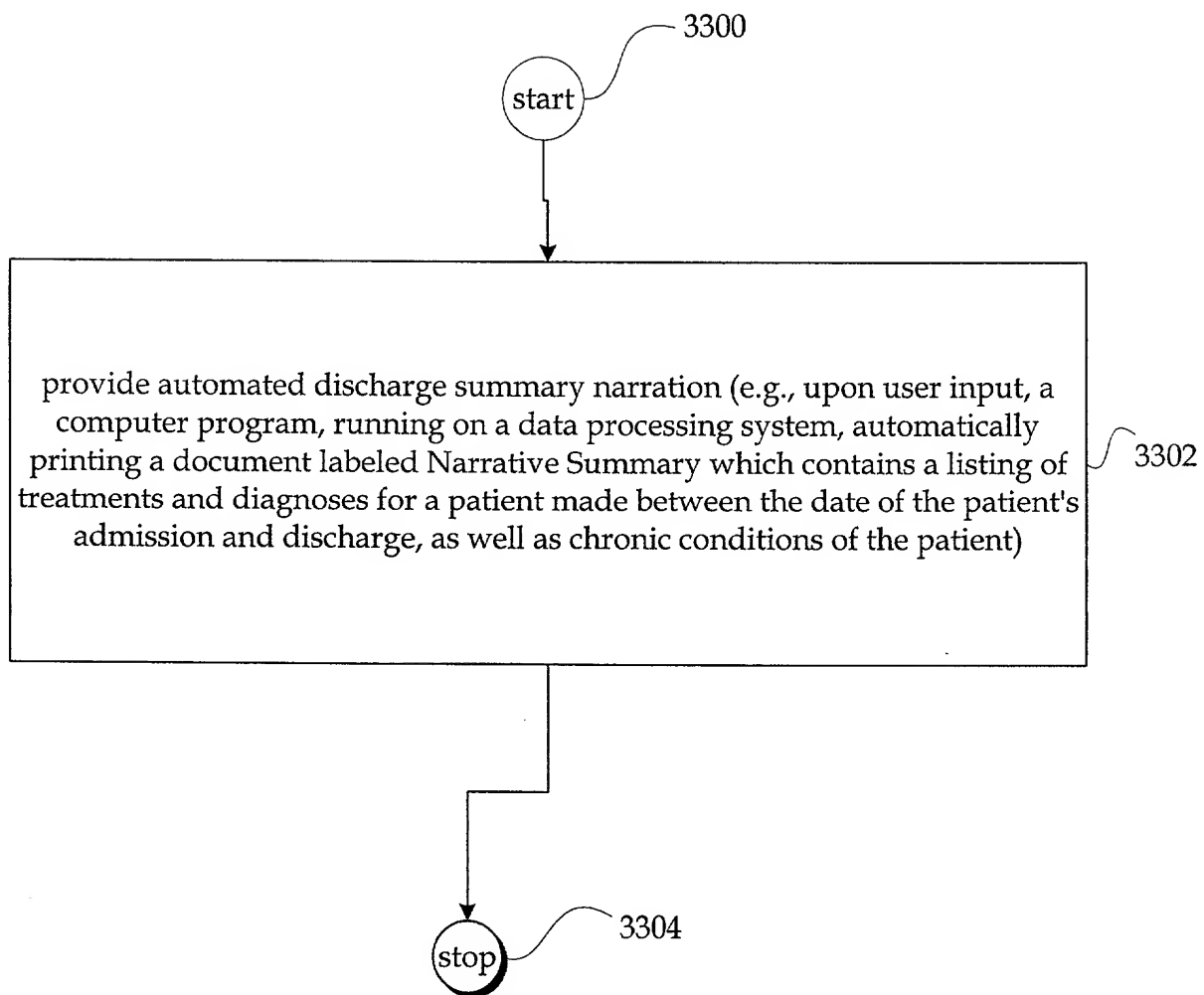
**Fig. 30**

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*Fig. 31*

*Fig. 32*

*Fig. 33*

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rtr: A- STD LABS NKDA

Discharge Summary Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Prior Admissions/Discharges

Adm Date	Disch Date	Review Date/Time	Rt
23 Nov 2001	23 Nov 2001	25 Nov 2001 0900	ev

Delete Discharge... Total: 1

Discharge Date: 25 Nov 2001 Time: 0900 Discharging Phys: drmann

Admission Complaint/Reason(s) Comment

RUPTURE OF MEMBRANES

Final Diagnosis Summary: (This will show as delivered if there is a Stage 3 Date)

38 week/0 day IUP, delivered 1 Liveborn, FEMALE weighing 3560 gms with apgar scores of 8/9. Delivery via SVD.

Procedures Performed:

- AUGMENTATION OF LABOR, OXYTOCIN
- EPIDURAL
- FENTANYL
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INTRATHECAL ANESTHESIA
- MIDLINE EPISIOTOMY

(Note: If delivery was an Extrauterine Pregnancy and it is shown as an IUP, you must add Extrauterine Pregnancy to the Pb List or Compl screen and then click Refresh.)

Go Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office

Microsoft

Start Slide Inbo... CD Inbo... CHC CHC FW RE Micr... ST 2:16 PM

Fig. 33A

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**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0.0-0-0 EDC: 06 Dec 2001 Gest Age: 38: 0/7 Type/Rh: A+ STD LABS NKDA

**Discharge Summary** Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

**Significant Findings From Admission:**

Finding/Health Condition	Type	Comment
CEPHALIC PRESENTATION	PRESENTATION	
LABOR, LATENT	ADMISSION	
NO LACERATION	LACERATION	
SRON (SPONTANEOUS RUPTURE OF	ADMISSION	
VAGINAL DELIVERY	DELIVERY TYPE	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Doc Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Print Help

Office Microsoft

Start Slide... Inbo... CD... Inbo... CHC... CHC... PW... RE... Micr... ST... 2:16 PM

Fig. 33B

**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests HS Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age 35 G/P 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

### Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

**Significant/Chronic Findings from History:**

Finding/Health Condition	Type	Comment
ADVANCED MATERNAL AGE	ANTEPARTUM	
ADVANCED MATERNAL AGE	HISTORY GENERAL	
ADVANCED MATERNAL AGE	VISIT ASSESSMENT	
LEEP	ANTEPARTUM	SURGICAL Hx - Cervix > 4 cm on 4/26/01
SINGLE PARENT ACTIVE DUTY	ANTEPARTUM	No plan of marriage-FOB - min involved
STERILIZATION, DESIRED	ANTEPARTUM	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Doc Screen Mark Reviewed/Save/Close Save/Close Save Cancel Reset Help

Office Microsoft

Start Slide Inbo CD Inbo CHC CHC FW RE Mict ST 2:16 PM

Fig. 33C



**STORC - Standard Obstetrics Record Charting System**

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

### Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

**Discharge Medications**

Medication/Drug Name	Entered By	23
VITAMIN PRENATAL (PNV)	ewhiggin	23
Motrin (Ibuprofen)	ewhiggin	23
Colace	ewhiggin	23
Iron	ewhiggin	23

Add Delete Add Standard Meds

(Note: The Condition, Limitation and Diet values will be set to the appropriate defaults when one of the std instructions is selected.)

Condition on Discharge: STABLE, DELIVERED

Limitations on Activities: PELVIC REST FOR 4-6 WEEKS

Diet: REGULAR Narrative Summary Dictated? ☐ Yes ☒ No

**Follow-Up Instructions**

Return to: RAMSTEIN Facility

OB/GYN Clinic

In: 6 ☒ Weeks ☐ Days

**Other Instructions:** Select Std Instruction: NSVD Comp YD C/S PTL Previs

Pelvic rest (no intercourse or douche) for 4-6 weeks.  
Return for evaluation of temperature >100.5, bleeding > menses, vomiting, pain, foul discharge.  
Pericare for episiotomy if applicable.  
Avoid tub bathing for 2 weeks.  
Return to gentle exercise/activity in 2 weeks as tolerated.

Doc Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Repeat Help

Office Microsoft

Start Slide Inbo CD Inbo CHC CHC PW RE Mic ST 2:17 PM

Fig. 33D

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Enter any additional comments in the space provided below. If the comment can be recorded/entered elsewhere on one of the Discharge screens, you should use that space/method in order to make the data available for future analysis and research. (Maximum length of text is 255 characters)

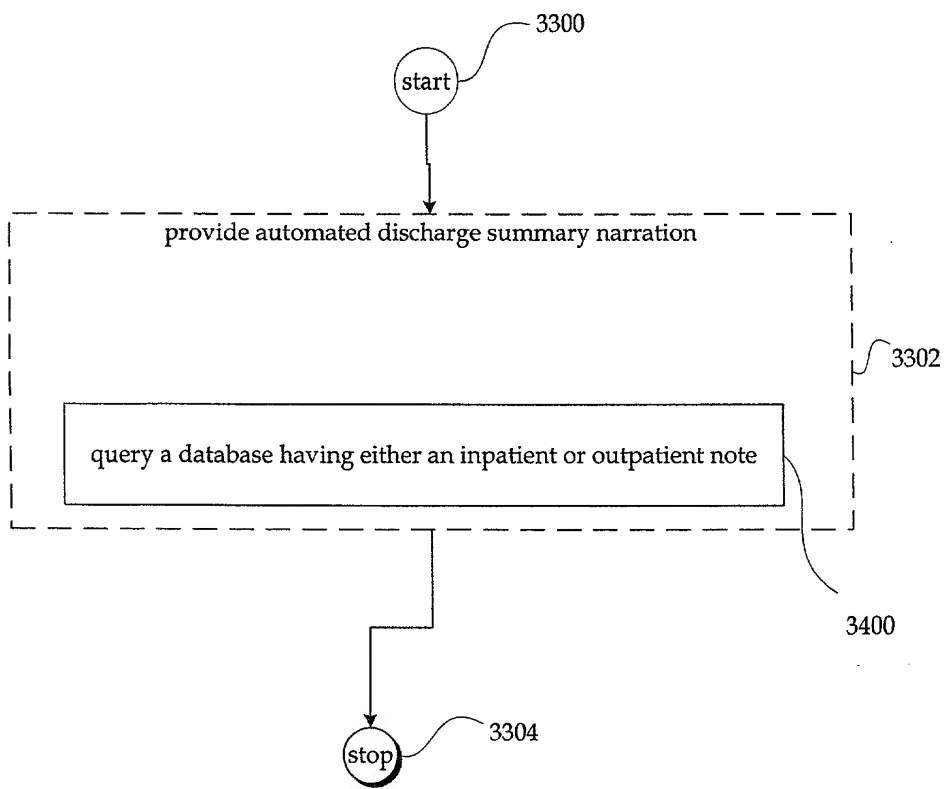
Doc Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Next Help

Office Microsoft

Start Slide... Info... CD... Info... CHC... CHC... PW... RE... Micr... ST... 2:18 PM

33E

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*Fig. 34*